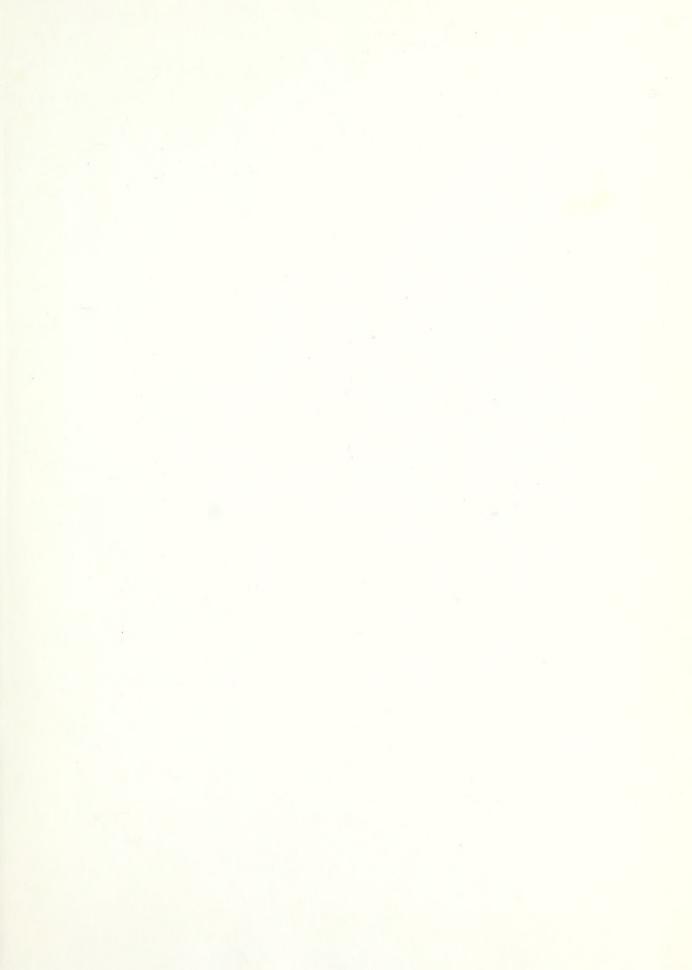
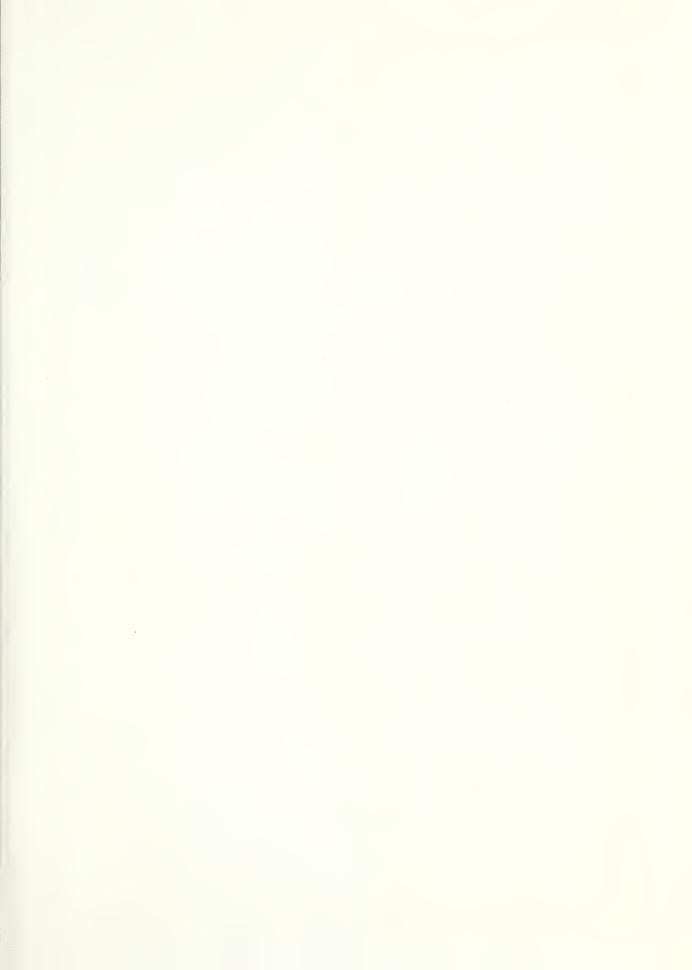


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Chiropractic & Public Law 92-603—Page 7

Coronary Prevention Trial—Page 19

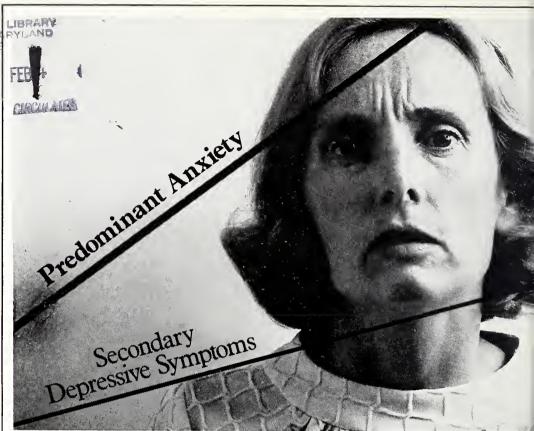
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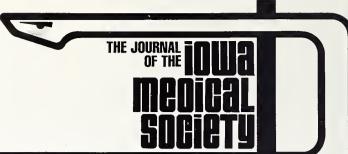
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred

vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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VOL. 64 No. 1 JANUARY, 1974

TABLE OF CONTENTS		SPECIAL DEPARTMENTS					
Chiropractic and Public Law 92-603 H. Thomas Ballantine, M.D.	7	President's Page  Iowa Medical Miscellany					
The Coronary Primary Prevention Trial Philip A. Habak, M.D., Helmut G. Schrott,	10	State Department of Health	12				
M.D., and William E. Connor, M.D.	19	The Question Box					
Disability in Iowa Homer E. Wichern, M.D.	23	Educationally Speaking	18				
	23	Doctor's Business	31				
Angiomyolipoma of Kidney: Report of Two Cases Studied Angiographically Steven H. Cornell, M.D., and Robert A. Boldus, M.D.		Medical Assistants	32				
	٥٢	In the Public Interest	33				
	25	About Iowa Physicians	35				
		Deaths	38				
EDITORIALS							
Your Future	28	MISCELLANEOUS					
Who Does the Killing?	28	Continuing Education Courses and Con-					
Quiet—Hospital Zone		ferences					
Suffer the Little Children	30	Pediatric Conference	30				

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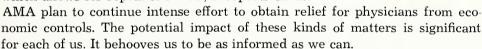
# President's Page

How do you stay informed on medical care delivery?

It's an awesome challenge. The magnitude, the complexity and the limited availability of time make it so.

AMA President Russell B. Roth, M.D., reportedly places great reliance on the weekly american medical news. And he's one of the nation's most articulate and knowledgeable persons on medical affairs. Very likely his key source of current national information could function similarly for each of us.

The December 10 issue now before me goes right to the "nuts and bolts" issues, e.g., it tells of the recent action of the AMA House of Delegates which allows for repeal of PSRO; it reports on the



In this vein, the Society seeks to keep you informed at the state level. IMS News Bulletins, the JOURNAL and the IMS Report are our principal mechanisms for distributing information.

As 1974 begins—with resolutions in order—let's each of us resolve to squeeze out those few minutes it takes to become informed, at least generally, on what's happening in and to our profession.

Sincerely,

Rubin Flocks, M. D.

Rubin Flocks, President

# IOWA Medical Miscellany

PSRO... Iowa is one of 25 states tabbed by HEW as a single statewide PSRO area. Announcement to this effect was made December 20 in the FEDERAL REGISTER with final approval scheduled for January 20. The other states will have multiple PSRO units within their borders.

POMRS . . . IMS and Iowa Hospital Association will co-sponsor a January 16-17 conference in Des Moines on the Problem Oriented Medical Record System. Stephen Yarnall, M.D., President, Medical Computer Services Association, Seattle, Washington, will present the program at the Hotel Fort Des Moines. Society members have been provided specific details and registration cards. Attendance is encouraged.

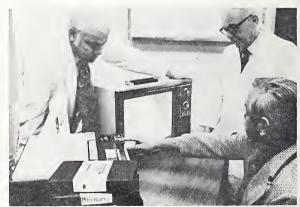
GENERAL ASSEMBLY... The Iowa General Assembly will re-convene January 14. IMS Legislative Committee, under new chairman D. C. Young, M.D., Des Moines, has assigned priority status to pending legislation dealing with chiropractic, patient records, professional licensing, generic prescribing and third-party reimbursement (see page 15).

NOW EFFECTIVE . . . The new federal program of Supplemental Security Income for the aged, blind and disabled became effective January 1. Two groups of persons are eligible for Medical Assistance (Medicaid) under the program: (1) persons receiving a payment through the SSI Program for the aged, blind and disabled, and (2) certain persons in a medical institution (hospital, skilled nursing facility or regular licensed nursing home) who meet all eligibility requirements for the SSI Program except for income.

**RE-ELECTED...** E. E. Gamet, M.D., and A. J. Soucek, D.D.S., were recently re-elected president and vice-president, respectively, of the Iowa State Board of Health.

CONTINUING EDUCATION . . . Input from the IMS Committee on Medical Education and Hospitals has been provided the State Board of Medical Examiners in its preparation of a mid-January report to the Iowa General Assembly. The report must contain continuing education recommendations. Society House of Delegates reaffirmed importance of continuing medical education in October and requested the IMS, Board of Medical Examiners and Iowa Society of Osteopathic Physicians and Surgeons to work together in devising an acceptable program of documentation.

ALCOHOLISM . . . IMS Committee on Alcoholism will be briefed January 10 on proposed state legislation dealing with detoxification. Committee meeting is in Cedar Rapids where several members will participate in a panel discussion before the Linn County Medical Society.



NEW EQUIPMENT . . . University of Iowa Urology Department has received a color television videocassette system on long-term loan from Eaton Laboratories. Eaton district manager Patrick McGuire demonstrates equipment here for Rubin Flocks, M.D., and D. A. Culp, M.D., head and vice-chairman, respectively, of the Department.

Inclusion of chiropractic under Medicare is permitted under P.L. 92-603. Impact of this on state practice acts is uncertain. Definition of subluxation remains shrouded in mystery.

# Chiropractic and Public Law 92-603

H. THOMAS BALLANTINE, M.D. Boston, Massachusetts

EIGHT SHORT YEARS AGO, the United States Congress passed and the President signed into law, a most important piece of social legislation: the Social Security Act, and particularly Titles XVIII and XIX: The Medicare and Medicaid entitlements.

The intent of this legislation was most praiseworthy and was well expressed in a statement by the Department of Health, Education and Welfare that: "Charity Medicine is being abandoned in favor of programs which give needy people the resources to purchase medical care from private physicians and hospitals on the same basis as more affluent citizens."

Our political leaders quite evidently believed that removal of economic barriers to access to high quality medical care would provide that care to that segment of American society which needed it the most. However, this legislation did not really address itself directly to the problem of quality. This, the chiropractors understood and, as soon as the 1965 legislation became law, the chiropractors, sensing an economic bonanza, began to clamor for inclusion.

So great were their political machinations that, in desperation, the 90th Congress in 1967, directed the Secretary of Health, Education and Welfare to undertake a study concerning

"independent practitioners," including chiropractors. The study findings were submitted to Congress in December, 1968, by the then HEW secretary, Wilbur J. Cohen.

Secretary Cohen recognized the impact any changes in Medicare and Medicaid legislation could have on the total health care system and stated: "Contemplated changes in coverage should be approached with caution, and with full awareness of the role of Medicare as an agent of change. Hasty changes, made without adequate information and without thorough debate, exploration and preparation within the health care community could be damaging not only to Medicare beneficiaries, but also to the total population."

During the investigation of chiropractic by HEW, the cult's foremost spokesmen presented claims which were to the effect that chiropractors possessed expertise in the diagnosis and treatment of almost all human ailments and extolled the beneficial effects of the treatments they offered. Were these claims false and deceptive? Let us examine the evidence.

# HEW FINDINGS

The HEW findings, after the most thorough study of chiropractic ever undertaken, were stated simply and forcefully in the report to Congress:

"Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment."

Dr. Ballantine is chairman of the American Medical Association Committee on Quackery. This paper was presented at a meeting of the Iowa Health Council, Des Moines, Iowa, October 17, 1973. Dr. Ballantine is associate clinical professor of surgery at Harvard Medical School, senior neurosurgeon at Massachusetts General Hospital in Boston, and maintains an active medical practice as a neurosurgeon.

The HEW recommendation to Congress was equally forceful and simple:

"Therefore it is recommended that chiropractic service not be covered in the Medicare program."

The criticisms of HEW regarding the scope and quality of chiropractic education require a few further comments. For example, as of this date, none of chiropractic's so-called colleges has been accredited as an acceptable educational institution by any officially recognized national accrediting body.

As recently as March of 1973, the two separate national chiropractic organizations appeared before the U. S. Office of Education to present formal testimony concerning their ability to act as accrediting agencies for the chiropractic schools. The Office of Education has rejected the applications of both groups and, in giving the reasons for such rejection, it clearly spelled out the inadequacies of chiropractic education.

### WISCONSIN STUDY

I understand that the Iowa State Board of Health has recommended a study of chiropractic education in order to be in a position to comment on a bill before the Iowa General Assembly which would expand the scope of the Chiropractic Practice Act. This action by the Iowa State Board of Health follows a precedent set by the State of Wisconsin.

In that state, the Governor assembled a health planning and policy task force. That task force included a chiropractic study committee. And, in October, 1972 (just about the same time that the Congress was including chiropractors in Medicare and Medicaid), the Wisconsin chiropractic study committee made its findings public. The Wisconsin study committee was composed of a Milwaukee lawyer, a University of Wisconsin pharmacy professor and a Wisconsin labor leader. There was no physician representation. The committee found that chiropractic education was woefully inadequate and commented that "it is anachronistic to permit an academically unrecognized, scientifically unproven and medically uncontrolled method" to infringe on the right of the public to medical care of acceptable quality.

Several recommendations of that Wisconsin study committee are worthy of note at this

time when the Iowa State Board of Health is undertaking its study. The committee recommended, among other things, that the state inform its citizens of the potential hazards of chiropractic; that the task force oppose any legislation requiring coverage for chiropractic in any form of insurance policy; that the state prohibit the use of public resources to further the use of chiropractic, and that legislation be enacted to remove chiropractic from coverage by the Wisconsin Workmen's Compensation Law.

### PL 92-603

But to return to our story: despite the firm opposition of the Department of Health Education and Welfare, the chiropractors continued to press for inclusion of their services under Medicare. Each year, bills were introduced to allow such inclusion and each year, concerned groups of citizens—those citizens worried about the quality of health care in America—spoke out and wrote in opposition to such inclusion.

Among the many opponents of this chiropractic legislation were: the AFL-CIO, the National Council of Senior Citizens, the American Public Health Association, the Consumer Federation of America and many medical specialty associations. Finally, it was widely believed that Congressman Wilbur Mills, the father of the original Medicare legislation, was himself opposed to chiropractic inclusion under Medicare.

Then came 1972, and the bill known as HR1, which became PL 92-603 on October 30, 1972. Among the many additions that the Social Security Amendments of 1972 made to the Social Security Act was the extension of Medicare benefits to a significantly increased number of our citizens under the age of 65.

Moreover, it mandated the creation of professional standards review organizations which are designed to monitor medical care delivery with a view to increasing both the quality and the cost effectiveness of the delivery of medical care to Medicare-Medicaid beneficiaries. But, most ironic is the fact that PL 92-603 allows chiropractors to collect federal monies for carrying out spinal manipulation on Medicare patients. So—while part of PL 92-603 is devoted to attempts to improve the quality of medical services, another part—the chiropractic legislation—is doing just the opposite.

The President's National Advisory Commit-

tee on Health Manpower succinctly placed this problem in proper perspective when it stated that "although chiropractic is not the only existing cult it is the only one which still constitutes a significant hazard to the public."

The recent strange turn of legislative events has been scrutinized by two nationally syndicated columnists.

Richard Lyons stated in a NEW YORK TIMES article on November 19, 1972:

"After seven years of ceaseless lobbying, chiropractors have finally succeeded in getting themselves included in the multibillion-dollar Medicare program through a series of events that offers a view of the workings of Washington in microcosm.

"The cast of characters involves a small but determined band of chiropractors, their patients, lobbyists for and against their cause, senators and representatives, federal officials, campaign contributions and tens of thousands, if not millions, of pieces of mail."

Harriet Van Horne stated in her widely syndicated newspaper column on December 23, 1972, that: "It was the bags and bags of letters—a steady, seven-year avalanche—that finally brought the dubious profession of chiropractic into the great bonanza of Medicare."

### MILLS ACTION

But, there is one other factor which should be noted. Congressman Wilbur Mills is Chairman of the House Ways and Means Committee. No important piece of health legislation goes to the floor of the House without his approval, and it must be regretfully said that Mr. Mills did vote for the inclusion of chiropractic in what was then known as HR1—destined to turn into PL 92-603.

Congressman Wilbur Mills gave the 1973 commencement address at Palmer College of Chiropractic, after which he was awarded an honorary degree for his services to chiropractic. So non-science triumphs politically and the chiropractors were victorious.

Or were they?

For example, in the article by Lyons, which I mentioned earlier, he observes that the chiropractors might have won a battle but lost a war. Could this be true?

The chiropractic legislation embodied in PL 92-603 is short, simple and inconclusive. It states, effective July 1, 1973, there shall be add-

ed to the services available under the Medicare program those of chiropractors who "meet uniform minimum standards promulgated by the Secretary of HEW," but that these services shall be available "only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by x-ray to exist)."

## RULES AND REGULATIONS

In American legislative activity, a law is only a bare skeleton, which must be fleshed out and made operative by Rules and Regulations, developed by the agencies involved and published in the FEDERAL REGISTER. Proposed Rules and Regulations were published on June 29, 1973, but it is most important to note these are tentative and are subject to change if good and sufficient reasons can be given for such change.

The Regulations address themselves to three vital issues:

- 1. The setting of minimal educational standards to be met by participating chiropractors.
- 2. The scope of coverage of chiropractic services.
- 3. The quality control of chiropractic services.

Unfortunately, in the publication of these proposed regulations, HEW failed on every one of the issues enumerated above. We in organized medicine, however, have an opportunity to help in the formulation of reasonable and better rules and regulations. But, first, let's examine those that currently exist—the proposals.

First, in reference to the participation by the chiropractic community and the educational standards to be met by chiropractors: HEW accepts a mediocre average of the educational criteria developed by the various states. Even so, the regulations do require that a participating chiropractor pass a licensing examination and since more than half of the practicing chiropractors in some states have been licensed under grandfather clauses and have never taken examinations, the chiropractors have their first barrier to access to the Medicare trough. For example, as of this date, only 97 of 285 registered chiropractors in Massachusetts have met the eligibility requirements to the satisfaction of HEW.

Nevertheless, HEW has not faced in a courageous fashion the real problem—the quality

of chiropractic education and the fact that no chiropractic school has ever been accredited by the U. S. Office of Education or the National Commission on Accrediting. If the public is to be protected, should not this minimum standard required of our schools of veterinary medicine, podiatry, optometry, as well as medicine and osteopathy, be met by schools of chiropractic?

A second problem for HEW is the scope of chiropractic coverage. The proposed Regulations state that "payment may be made only for the chiropractor's manual manipulation of the spine to correct a subluxation (demonstrated by x-ray to exist) which has resulted in a neuromusculoskeletal condition for which such manipulation is appropriate treatment."

If these HEW requirements are followed strictly by the Medicare carriers, it will at last be possible to gather scientific data concerning chiropractic allegations as to the cause and cure of disease. You will recall that chiropractic clings tenaciously to the teachings of Daniel David Palmer, dating back to 1895, that all disease is caused by a vertebral subluxation and can be cured by manual manipulation of the spine. Very simple isn't it? One cause, one cure.

# MEDICARE REQUIREMENTS

However, to collect a federal payment for treating a Medicare beneficiary, a chiropractor will now be required to:

- 1. Diagnose a "neuromusculoskeletal condition" which is existent in the patient he wishes to treat.
- 2. Determine that the condition has been caused by a vertebral subluxation.
- 3. Demonstrate that subluxation by appropriate x-rays (which HEW will *not* pay for!).
- 4. State that manual manipulation of the spine is the appropriate treatment.

And, furthermore, the carriers will be obliged to develop criteria for:

- 1. Defining a neuromusculoskeletal condition.
  - 2. Defining the term "subluxation."
- 3. Developing precise indications for the diagnosis by x-ray of a subluxation.
- 4. Determining which, if any, neuromusculoskeletal conditions are caused by vertebral subluxations.
- 5. Developing quality assurance guidelines to determine when manual manipulation of a

spine should be used to treat patients with these conditions.

6. Developing utilization standards to prevent overtreatment as well as inappropriate treatment.

This is a Herculean task. But those of us concerned with the quality and cost-effectiveness of health care delivery must be firm in our demands that all of the questions and criteria which we have listed here are answered very, very clearly and without equivocation.

An example of one statement that must be clarified is this current HEW definition:

"A subluxation will be deemed present when an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae is anatomically demonstrable on an x-ray film to individuals trained in the reading of x-rays."

This definition of subluxation is so broad, so all-encompassing, as to be medically meaning-less. It is, in fact, ridiculous. Each of us in this room probably has a subluxation under such a broad definition. It is incumbent upon health professionals to demand a clearer expression of just what the term subluxation is designed to mean.

The term "musculoskeletal condition" has yet to be defined and to my knowledge no one has compiled a listing of those neuromusculoskeletal conditions which are caused by subluxations, much less those which can be treated by spinal manipulations.

### TESTS THEORY

The only scientific evidence available on this latter score appears in the September-October, 1973, issue of *American Scientist* under the title: "A Scientific Test of the Chiropractic Theory" by Edmund S. Crelin, Ph.D. Dr. Crelin describes an experiment in which he applied forceful compression to vertebral columns obtained from male and female infants and adults.

In his paper, he states unequivocally that:

"This experiment demonstrates conclusively that the subluxation of a vertebra as defined by chiropractic—the exertion of pressure on a spinal nerve which by interfering with the planned expression of Innate Intelligence produces pathology—does not occur."

If Professor Crelin is correct, as I firmly believe him to be, then PL 92-603 sets up a

mechanism to pay for unnecessary manipulation of the spine to correct a non-existent condition!

If this is true, then Section 273 of PL 92-603 is in violation of Section 1862 of the original Social Security Act which states that "(a) not withstanding any other provisions of this title, no payment may be made under part (A) or part (B) for any expenses incurred for items of services (1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member...."

### CONFUSION REIGNS

At this juncture, I would welcome you to the Department of Utter Confusion created by Congress, at the urging of the chiropractors, with extra help from our Department of Health, Education and Welfare!

In all honesty, however, I must come to the defense of HEW. For the most part, HEW is made up of devoted and intelligent individuals of integrity who are faced with an almost impossible situation. They know that chiropractic is quackery and yet they also have a mandate from Congress to include this cultist practice as a Medicare benefit.

Some of these individuals are justifiably bitter that we—that is, organized medicine—that all of us have not spoken out adamantly enough concerning this issue. They would welcome comments from all members of the health care delivery system concerning this vital problem.

I am happy to report that the Iowa Medical Society has submitted its forthright comments on the proposed chiropractic standards and regulations, insofar as Medicare is concerned. And, despite the fact that the deadline for submission of official comments has passed, I am certain that letters to the new Commissioner of the Social Security Administration, James B. Cardwell, or to Charles C. Edwards, M.D., the former Iowan who is HEW Assistant Secretary for Health, would be given every consideration.

The FEDERAL REGISTER included in October, 1973, the published tentative regulations for chiropractic participation in Title XIX-Medicaid. Iowa is one of the states that includes chiropractic as a covered Medicaid service. We believe that Medicaid participation by chiropractic should, at the very least, be restricted

to the same standards and regulations that ultimately will be established by chiropractic under Medicare.

In summary then, the inclusion of chiropractic in PL 92-603, presents a unique opportunity to the scientific community to direct a piercing beam of scientific inquiry at the cult of chiropractic. We must demand of HEW and the Medicare carriers, without equivocation, that payment be made only for the chiropractor's manipulation of the spine to correct a subluxation demonstrated by x-ray to exist which has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment. This is one of the most fateful statements that ever has been made in reference to chiropractic service.

We must further demand clear and precise definitions of subluxation and of the term neuromusculoskeletal condition. We must have the scientific community, as well as the chiropractic, agree on the neuromusculoskeletal conditions which can be treated by spinal manipulations. We must insist that, at the outset, the chiropractors and physicians agree upon a common set of characteristics by which a subluxation can be identified in an x-ray film.

# MEET REQUIREMENTS

We must insist that schools or so-called "colleges" of chiropractic meet the same basic requirements as those others which educate in the field of delivery of health care to man and his animal friends. That is, no chiropractor should be allowed to ply his trade unless he has been graduated from a chiropractic institution which has been approved by the Office of the U. S. Commission of Education and the National Commission on Accrediting.

Finally, we must insist that the scientific validity of the teachings in chiropractic schools be subjected to the scrutiny and approval of the scientific community.

In conclusion, I wish to quote this important statement from the National Council of Senior Citizens: "Chiropractic treatment designed to eliminate causes that do not exist while denying the existence of the real causes is at best worthless—and at worst, mortally dangerous."

The truth of this statement has never been and never can be successfully challenged. Thus the real challenge to those of us in and out of government who are dedicated to the provision of high quality medical care is obvious.

# State Department of Health

# INCREASED THREAT OF GONOCOCCAL OPHTHALMIA NEONATORUM

From 1969 through 1972 Iowa had a 40% increase in reported cases of gonorrhea, with an additional 6% increase in the first 9 months of 1973 as compared to the same period in 1972. Since slightly less than half of the reported cases occurred in women of childbearing age, it is reasonable to assume that the risk of encountering ophthalmia neonatorum in the cause of perinatal care has increased accordingly. Four cases of this syndrome were reported to the State Department of Health in 1972. Iowa's experience has not been unique, but rather represents a small segment of a nationwide epidemic of this highly contagious venereal disease.

To meet the increased threat of gonorrheal infection in the newborn, the Preventive Medical Service of the State Department of Health calls the attention of practicing physicians to the following statement by the Committee on Ophthalmia Neonatorum of the National Society for the Prevention of Blindness.

### CONTROL OF OPHTHALMIA NEONATORUM

Gonococcal ophthalmia neonatorum is acquired during passage through the birth canal where infection with Neisseria gonorrhoeae takes place. Although no procedure assures 100% protection, infection of the newborn baby's eyes can usually be prevented by the Credé's prophylaxis procedure, which calls for the instillation of one per cent silver nitrate solution in the conjunctival sac at birth.

The Committee on Ophthalmia Neonatorum of the National Society for the Prevention of Blindness, with the official endorsement of committees\* of the American Academy of Ophthalmology and Otolaryngology, the American Academy of Pediatrics, and the American Medical Association, makes the following recommendations on prophylaxis and treatment:

# Prophylaxis

The Committee recommends continued use of one per cent silver nitrate in single-dose containers as the prophylactic agent of choice. Because there is concern about the remote possibility that babies might develop a sensitivity to any antibiotic that might be used, and because use of antibiotics might encourage the colonization of antibiotic-resistant organisms in babies in a nursery, their routine use as prophylactic agents is inadvisable until further research produces more precise information than is presently available. (Nothing is presently known about the production of resistant strains of gonococcus and other organisms in nurseries as a result of the use of antibiotics for prophylaxis. This lack of knowledge and the impracticability of having fresh solutions of the antibiotics always at hand cannot be emphasized too strongly.)

The Committee urges that cervical cultures from all expectant mothers be taken for the detection of an asymptomatic gonococcal infection.

# Treatment

The Committee recommends the prompt culturing for gonococci as well as prompt treatment of any ocular infection or other inflammation in the newborn. Antibiotics may be

<sup>\*</sup> Committee on Drugs, Ophthalmology, American Academy of Ophthalmology and Otolaryngology; Committee on Fetus and Newborn, Committee on Infectious Diseases, and Committee on Drugs, American Academy of Pediatrics; Committee on Maternal and Child Care, American Medical Association.

used for treating infection. The importance of re-examination of the baby after hospital discharge when any inflammatory condition or infection has been detected or suspected is emphasized.

# Proper Instillation of Silver Nitrate

Gonococcal ophthalmia neonatorum can usually be prevented by the proper application of the Credé's prophylaxis. This procedure calls for the instillation of one per cent silver nitrate solution into both of the infant's eyes within the first hour after birth. The Committee on Ophthalmia Neonatorum stresses the importance of performing the instillation so that the silver nitrate reaches all parts of the conjunctival sac. This can be accomplished by careful manipulation of the lids with the fingers to insure spreading of the drop. If the medication strikes the lids and lid margins only and fails to strike the cornea, the instillation should be repeated. If the Credé's prophylaxis is properly performed, a mild chemical conjunctivitis should result. The Committee on Ophthalmia does not recommend irrigating the eye after instillation of one per cent silver nitrate.

Failure of this method to prevent infection can occur especially if an infected mother's membranes rupture prematurely, exposing the baby's eyes to infection for hours or days prior to delivery. Since ophthalmia may also be a manifestation of neonatal sepsis, one should be alert to this possibility to insure prompt recognition and vigorous treatment.

# IOWA LAW

The preceding recommendations by the National Society for the Prevention of Blindness Committee on Ophthalmia Neonatorum are the same as they have been in the past. The recommendations and policies of the Iowa State Department of Health agree with the Committee's recommendations.

Iowa law requires that "each physician attending the birth of a child, shall cause to be instilled into the eyes of the newly born infant" one of the following prophylactic medications approved by the State Department of Health:

- 1. One per cent silver nitrate from unopened wax ampules in each conjunctival sac followed by normal saline flush, or
  - 2. Penicillin ointment in the strength of not

Another important type of ophthalmia neonatorum, inclusion conjunctivitis, is not preventable by the Credé's prophylaxis, nor does silver nitrate affect staphylococci and other types of infectious agents causing conjunctivitis in the newborn.

# Legislative Requirements

The use of prophylactic agent in the eyes of all newborn babies is required by law or regulation in 47 states and the District of Columbia. In the remaining three states, the requirement is limited as follows: "to births attended by midwives," and "to cases in which the presence of disease is suspected." The regulations in these states also direct the "State Department of Health to furnish free prophylactic." In 10 states, the requirement may be waived if parents object.

Silver nitrate is the only prophylactic agent specified or approved for use in 15 states; in 33 states and the District of Columbia, silver nitrate or "other equally effective agent" may be used. In two states, a particular prophylactic agent is designated.

# Reporting

The Committee recommends that all physicians and hospitals be required to report their gonorrheal ophthalmia neonatorum cases to state or local health departments, or both, so that incidence data may be obtained to determine the effectiveness of the control measures.

less than 100,000 units per gram, or

3. Erythromycin ointment in the strength of not less than five milligrams per gram.

Because approximately 80% of gonorrheal infections in females are asymptomatic, the State Department of Health recommends that bacteriologic culture for N. gonorrheae be included as a routine part of all prenatal gynecological examinations in order to detect and treat maternal infection prior to the time of delivery. The State Department of Health now provides all Iowa physicians free gonococcal bacteriologic culture service, which may be used for this purpose. For details, please write the Iowa State Department of Health, Venereal Disease Division, Lucas State Office Building, Des Moines, Iowa 50319, or telephone 515-281-3031.

# THE PREMATURE "DRI-DOT"

The Organon Company began marketing a serological test for gonorrhea in kit form, under the trade name of "Gonosticon Dri-Dot." The Venereal Disease Branch of the U. S. Center for Disease Control, has summarized in the accompanying table the complete data presented by the company in support of this product. The V.D. Branch also offers the commentary that the field trials were conducted by several different investigators in several different geographic areas with results varying widely as shown by the ranges given in parentheses under the various categories of the table.

In general, the test correlates with a past history of gonorrhea rather than providing an indication of recent or present infection. No data was presented for patients known to have no past history of gonococcal infection. Based on the minimal information which is available and the fact that it has not been subjected to scientific scrutiny either in publications or scientific meetings, the V.D. Branch advises that the commercial marketing of this particular serologic test may be considered "premature."

The Preventive Medical Service of the State Department of Health considers it important to bring this critique to the attention of Iowa physicians. Until further information is available to suggest the test is useful, the State Department of Health accepts as its position on this question the following summary as prepared by the V.D. Branch of the Center for Disease Control:

"Such data as are presented by Organon indicate that the 'Gonostricon Dri-Dot' test should not be employed as the screening test of choice in populations of either men or women at high risk for gonorrhea. Both the culture (men and women) and the Gram stain (men) are far more sensitive and specific tests in this setting. In populations at low risk from the disease, where such a test has most theoretical promise, little or no data on sensitivity has been accumulated. No data are presented on the test's sensitivity in asymptomatic men at low risk from the disease, and data are presented for only nine culture positive lowrisk females (four of whom were missed by the test). At the same time, in all fairness it must be pointed out that there are no published reports depicting the sensitivity of the culture technique in low-risk populations.

"Lacking the relevant data, our best judgment is that the 'Gonosticon Dri-Dot' test has an as-yet unproven potential for being helpful in screening females at low risk from gonorrhea where culture screening cannot be done. We also believe the test has a potential for harm. Many infected women will be missed if physicians choose *not* to take a culture in the female because they view the serological test as being more convenient.

"All users of this test should clearly understand that a positive test requires confirmation by a culture before treatment is given, and that a negative test should not be used to reassure either the patient or the physician that the patient is not infected."

### SUMMARY OF ORGANON FIELD TRIALS OF "DRI-DOT"

	(	Culture and/o	Smear Posit	live	Culture and/or Smear Negative				
		Hx GC		Unknown	Past l	Hx GC	Past H	Unknown	
	No.	%	No.	%	No.	%	No.	%	
	Tested	Reactive	Tested	Reactive	Tested	Reactive	Tested	Reactive	
I. Males:									
"High Risk"									
(Attending VD Clinics) .	. 210	55.7	805	77.5	184	38.6	621	34.3	
•		(47-81)		(35-96)		(35-48)		(16-58)	
"Low Risk"									
(Attending City Health									
Dept. Clinics)	. 4	50.0	0		15	100	235	9.4	
II. Females:									
"High Risk"									
(Attending VD Clinics)	. 108	82.4	277	72.2	103	63.1	371	47.4	
•		(72-86)		(63-82)		(41-92)		(26-84)	
"Low Risk"									
(Attending City H.D.									
Clinics)	. 9	44.0	0	_	17	70.6	714	3.6	
,						(29-100)		(0.6-100)	



# The Question Box

by DONALD C. YOUNG, M.D.

Donald C. Young, M.D., Des Moines, is new chairman of the IMS Legislative Committee. He succeeds John H. Kelley, M.D., Des Moines, who has been named to the Board of Trustees.

# As new chairman of a most important Society committee, you undoubtedly have an idea as to what the top issues will be in the 1974 Iowa General Assembly?

The biggest issue will most likely be the disposition of a much larger than expected budget surplus. There are legislators who want to use the surplus for tax relief. There are others who want to expand governmental services, salaries, etc. Debate will be active, particularly since a budget surplus is perfect political fuel for the legislative races this November. Other issues include creation of a State Department of Transportation, regulation of consumer credit, energy concerns, 65-foot double bottom trucks and collective bargaining for public employees.

# What are the principal health measures on the docket?

Several health related bills held over from the 1973 session await final action. These include expansion of the chiropractic practice act; revision of the Board of Medical Examiners; modification in internship and residency requirements for licensure; extension of drug prescribing authority for podiatrists; repeal of drug anti-substitution laws; establishment of statewide certificate of need requirements for health facility construction; creation of uniform standards for ambulance services; and restoration of statutes indicating the progression of individuals who may consent to autopsies.

# Is the Legislative Committee geared up for the weeks ahead?

The Committee spent several hours November 27 going over each piece of pending legislation. We will meet again during the session to review developments and consider our strategy. We plan a vigorous campaign to educate the Legislative Contact Men and county society officers regarding our program and the progress of legislation in which we are interested. This will involve an in-depth appraisal of prime bills, identification of key legislators, plus suggestions on how to be effective in grass roots contact.

# Have you identified the measures to which you will give priority attention?

For the first time, the Committee has devised a list of priorities. Each bill has been ranked by importance to the total interest of the Society. Five key legislative measures will receive priority attention: SF 33—chiropractic expansion (Passed House 67-29); SF 179—requires physicians, other professionals, hospitals, to allow an attorney, with written authorization of the patient, to inspect and copy a patient's records; SF 88—provides for inclusion of chiropractic and optometric services in private health insurance contracts; SF 477—changes professional and occupational licensing boards, including the Board of Medical Examiners; it proposes reducing the number of physicians from eight to five and it adds two lay people; and HF 431—repeals the drug antisubstitution law. I might add that more detailed information on these and other bills is available from IMS Headquarters.

# How can individual physicians and county

(Please turn to next page)

# medical societies be helpful to their legislators?

Our legislative program will only be as successful as the IMS members want it to be. This means effective grass roots contact with each legislator. Prior to January 14 each physician should personally contact his or her legislator. A courtesy call to let your senator and/or

representative know you are available for consultation with any health care legislation will be most beneficial. Encourage your county medical society to meet with your legislators in a relaxed atmosphere to discuss the IMS legislative program. And finally, when it becomes necessary to approach a legislator on a particular issue, do it with tact. Talk to him as a politician, not as a patient.

# Morbidity Report for November, 1973

Disease	Nov. 1973	1973 to Date	1972 to Date	Most November Cases Reported From These Counties	Disease	Nov. 1973	1973 to Date	1972 to Date	Most November Cases Reported From These Counties
Disease	1773	Date	Date	Trom these Countries	Disease	17/3	Date	Date	Troill these Counties
Chickenpox	544	11694	7860	Buena Vista, Floyd,	Meningitis, asep	tic			
				Linn	or viral	2	16	17	Johnson, Jones
Conjunctivitis	72	958	773	Black Hawk, Emmet,	Meningitis,				
				Wapello	bacterial	2	7		Black Hawk, Scott
Coxsackie A9					Meningitis, type				
infection	2	2		Dallas, Polk	unspecified	4	32		Scattered
Coxsackie B3					Meningitis, asep	tic			
infection	2	6		Linn, Page	assoc. w/Cox-				
Cytomegaloviru					sackie A9	1	- 1		Polk
infection	- 1	5		Linn	Meningitis, asep	tic			
Eaton's Agent					assoc. w/Cox-				
infection	8	26		Scattered	sackie B3	1	1		Tama
ECHO 4					Meningitis,				
infection	5	5		Jackson, Johnson, Linn	aseptic assoc.				
ECHO II					w/ECHO 4	1	2		Polk
infection	1	1		Polk	Meningococcal				
Encephalitis, typ	Эе				meningitis	1	21	5	Muscatine
unspecified	3	18	6	Black Hawk, Carroll	Meningoen-				
Encephalitis, ass	oc.				cephalitis	2	11		Clayton, Johnson
w/ECHO 4	- 1	1		Marshall	Mumps	375	3613	6525	Hancock, Jones, Tama
Encephalitis, vir	al				Pediculosis	22	187		Cerro Gordo, Linn
California	2	3		Linn, Winneshiek	Pertussis	2	20	42	Benton, Buchanan
Erythema	_	-			Pneumonia	114	1067	863	Scattered
infectiosum	1	1343		Dallas	Rabies in anima	ls I2	208	381	Scattered
Gastrointestinal	•	1343		Dallas	Ringworm, body	26	148	98	Scattered
viral infection	594	6614	5672	Dubuque, Floyd,	Rubella	3	219	427	Dubuque, Hamilton,
				Johnson		_		0//	Tama
Giardiasis	4	21		Scattered	Rubeola	2	282	864	Warren
Hepatitis,	•			Seamered	Roseola	2	6		Dubuque, Palo Alto
inlectious	46	217	275	Linn, Muscatine, Polk	Salmonellosis	30	207	111	Scattered
Hepatitis, serum		49	50	Johnson, Polk	Scabies	209	229		Appanoose
•		77	50	Johnson, Polk	Schistosomiasis	1	1		Polk
Hepatitis, type	•	2.1		61	Shigellosis	12	270	296	Scattered
unspecified	2	21		Story	Streptococcal				
Herpes simplex		71		Johnson	infection	904	6522	6283	Jackson, Johnson, Poli
Herpes zoster	2	20		Muscatine, Wapello	Tuberculosis,				
Histoplasmosis	2	10	23	Johnson, Wapello	active	9	117	113	Scattered
Impetigo	76	426	477	Dubuque, Jasper, Linn	Tuberculosis,				
Inlectious					inactive	- 1	18		Clinton
mononucleosi	s 62	669	961	Scattere <b>d</b>	Venereal disease	es			
Influenza-like					Gonorrhea	747	5966	5645	Polk, Scott, Woodbury
illness	1080	13502		Johnson, Linn, Warren	Syphilis	32	392	442	Scattered

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by RICHARD M. CAPLAN, M.D.

# UNIVERSITY HOSPITALS AND PHYSICIAN EDUCATION

I just read an attractive special report prepared to commemorate the 75th anniversary of the University of Iowa Hospitals and Clinics. A copy of it will be reaching you shortly. Watch for it—I think you'll find it interesting.

The description of activities and services taking place in the University's Health Care Center is impressive. For example, University Hospitals provided the setting and facilities for 65 of 193 continuing education programs offered in the 1972-73 academic year by the College of Medicine. Although some of these activities might have occurred elsewhere, their presentation in University Hospitals helps achieve a desirable expression of the continuity of medical education. For many of the programs, the availability of patients and special equipment required that they take place at the hospital.

The potential role of any hospital in respect

to education is immense. For University Hospitals the relationship is obvious. For small community hospitals the potential is present although not usually exploited sufficiently for the benefit of the health professionals and the patients they serve. As a locus for gathering talented personnel, equipment and dollar resources, patients, and the public generally, hospitals constitute a social institution of first magnitude.

Efforts are currently underway to mobilize such splendid resources more fully. Hospitals are now devoting increasing budgets to inservice training at all levels. The movement toward quality-of-care-assessment, whether motivated by sound professionalism, JCAH requirements, or the PSRO regulations, will surely produce valuable educational spinoff.

As I read the future for health services and education of health professionals of all types and levels, hospitals of all kinds will be enlarging their contribution. And University Hospitals and Clinics in Iowa City will surely continue its vital and unique role into a distant future.

# Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

1974 Feb. 9-10 Cammunity Clinical Conference (Estherville)

Jan. 5 Ophthalmolagy Clinical Canference Feb. 12-15 Refresher Caurse far the Family Physician

Jan. 28-31 Cardialogy Today Mar. 1 Ophthalmalagy Clinical Canference

Feb. 2 Ophthalmalagy Clinical Conference Mar. 6 Diet Therapy U.S.A.

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.



# The Coronary Primary Prevention Trial

PHILIP A. HABAK, M.D.,
HELMUT G. SCHROTT, M.D., and
WILLIAM E. CONNOR, M.D.
Iowa City

This report introduces to Iowa physicians a unique and important cooperative study whose objective is to prevent coronary heart disease. Many of the practicing physicians will have the opportunity to play a substantial role in the selection and referral of patients.

Atherosclerosis is a major cause of morbidity and mortality in North America and Western Europe. In the United States cardiovascular disease is responsible for 54.1% of all deaths and approximately 626,000 deaths (over 3 per 1,000) from atherosclerotic and degenerative heart disease were reported in 1967. In men 40-59 years of age, the death rate reaches 8 per 1,000 per year. The apparent increase in number of reported cases of clinical coronary heart disease over the past 50 years probably represents not only an improvement in diagnostic skills but also a real rise in incidence of the disease.

THE LIPID HYPOTHESIS

Theories of the etiology of atherosclerosis have implicated primary changes in the plasma, in the vessel wall or both. The lipid hypothesis, which implies a relationship between lipid metabolism and arteriosclerosis, has gained much popularity, and has been strengthened by the discovery that in several species of animals atherosclerotic lesions can be produced by high cholesterol, high saturated fat diets.<sup>2, 3</sup> Furthermore, Taylor *et al*<sup>4</sup> were able to produce fatal myocardial infarctions in Rhesus

lowa physicians are invited to participate in a study aimed at preventing coronary heart disease. Attempt will be made to decide if lowering blood cholesterol can reduce incidence of premature coronary heart disease in patients with hypercholesterolemia.

monkeys fed a high cholesterol diet. More recently, experiments in monkeys have shown regression of arterial plaques when a low cholesterol diet was subsequently introduced.<sup>5</sup> The Framingham Heart Study and other studies have clearly identified the level of the serum cholesterol as a major risk factor for atherosclerotic coronary heart disease.<sup>6</sup> Cholesterol enters in the formation of the atheromatous plaque from the blood as part of a lipoprotein

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JANUARY, 1974.

The authors are associated with The Lipid Research Clinic, Cardiovascular Division, Department of Internal Medicine, The University of Iowa College of Medicine, Iowa City, Iowa 52242.

molecule or as free or esterified cholesterol. Isotopic studies have demonstrated that the vast bulk of the lipoproteins and cholesterol found in atherosclerotic lesions originate from the plasma. Cholesterol is distributed throughout all the lipoprotein fractions of the plasma, except the albumin-NEFA (non-esterified fatty acids) complex. The low density or beta-lipoproteins contain a greater proportion of cholesterol than the other lipoprotein fractions. In addition, the low density lipoproteins alone among the serum lipoproteins are selectively bound to the arterial intimal and medial components and sections stained with anti-low density lipoprotein antibody show pronounced fluorescence in the same areas where substantial lipid deposition is present.

A high correlation exists between the concentrations of beta-lipoproteins and the incidence of atheromatous disease both in animals and in man.7 Beta-lipoproteins are synthesized by the liver and gut and their serum concentration depends on the balance between synthesis and degradation. The role of dietary cholesterol, fat content and the ratio between polyunsaturated and saturated fats in the genesis of atherosclerotic vascular disease may be related to alterations in the concentration of the beta-lipoproteins in the plasma. The association between elevated cholesterol levels and atherosclerotic coronary heart disease, although suggestive, does not in itself prove cause and effect. Studies of the efficacy of dietary or drug treatment have not yet been convincing because of the use of small numbers, lack of double blinding or reliance on soft end points such as angina pectoris. It then remains to be proven that lowering of plasma cholesterol levels is beneficial in reducing the death rate from premature coronary heart disease. Thus, a well designed, centrally coordinated, randomized, double blind primary prevention trial using patients with hypercholesterolemia is needed to substantiate the lipid hypothesis and the efficacy of intervention.

# THE LIPID RESEARCH CLINICS

The Lipid Metabolism Branch of the National Heart and Lung Institute was created in December, 1970. A network of continent-wide Lipid Research Clinics located in 12 universities in the United States and Canada was established. Their major objectives included the per-

formance of studies on the prevalence and natural history of the hyperlipoproteinemias and a primary prevention trial on patients with hypercholesterolemia to prevent coronary heart disease. The University of Iowa is among the institutions approved to participate in this major research goal and to host a Lipid Research Clinic. In addition, the Iowa Lipid Research Clinic staff will offer consultation and assistance to all physicians encountering management problems in patients with disorders of lipid metabolism. The Lipid Core Laboratory of the Clinic has been standardized according to the Lipid Standardization Laboratory of the Communicable Disease Center in Atlanta, Georgia. Thus, the Lipid Research Clinics throughout the nation are standardized with one another. The University of Iowa Lipid Laboratory will be available as a reference for the standardization of other laboratories in Iowa which perform various blood lipid studies and would provide assistance to any clinical laboratory wishing information regarding specific technical problems in the lipid field. The protocol for the primary prevention trial (also known as the Lipid Research Clinics Type II Coronary Primary Prevention Trial) was approved by the Lipid Research Clinics directorate in November, 1972.

# THE PRIMARY PREVENTION TRIAL PROTOCOL8

# I. Patient Population

A minimum of 300 patients per clinic, 35-59 years of age, will be enrolled in the project. These will be patients with Type II Hyperlipoproteinemia, also known as familial hypercholesterolemia. This condition is characterized by elevated levels of serum cholesterol and betalipoproteins and a clear fasting serum. It is sometimes associated with tendon nodules (xanthoma tendinosa), xanthelasma, and (less frequently) skin xanthomas of the tuberous type. It is frequently a hereditary disorder transmitted as a simple Mendelian dominant trait but may also occur in part secondary to a cholesterol-fat rich diet, hypothyroidism, nephrosis, dysproteinemias or obstructive liver disease. The patients referred to the prevention study should be healthy men having no angina pectoris, history of a myocardial infarction, coronary insufficiency or heart failure as well as severe hypertension. Patients with diabetes mellitus, other endocrine disorders and diseases

limiting life expectancy to less than 5 years also are not eligible for the study. In addition, they should not be receiving any of the following medications: estrogens or androgens, thyroid, steroids, anticoagulants, quinidine, procainamide and digitalis.

# II. Recruitment

The enrollment of 300 men with Type II Hyperlipoproteinemia between the ages 35 and 59 years into the study will require the screening of a much larger population that may amount to 10,000 subjects. Iowa physicians will play a central role in identifying and referring these patients. The physicians will be supplied with special test tubes and will be requested to send to the Lipid Research Clinic blood samples on their patients with elevated serum cholesterol (>285 mg%) who fulfill the other criteria for inclusion into the study and are willing to participate in the project if found eligible. The patients will be subsequently contacted by the Lipid Research Clinic. We would stress that the referring physician remains the primary physician for the patient with the Lipid Research Clinic staff serving only as consultants in the special area. The referring physician will be furnished with a copy of the initial medical evaluation, the cardiovascular workup and the results of all screening tests as well as reports of subsequent examinations.

It should also be mentioned that all patients referred to the study stand to benefit. These are some of the advantages to the participants:

1) general medical workup; 2) lipid and cardiovascular workup; 3) all patients will receive dietary counseling; and 4) there are no costs to the patient.

# III. Preliminary Evaluation

All patients will undergo an initial evaluation which will be spread over five monthly visits. The study will be explained to the patients individually and their consent will be obtained. In addition to a complete history and physical examination some of the visits will include a blood lipid profile, blood counts and blood chemistry, an electrocardiogram as well as a treadmill exercise test. All laboratory results obtained in the initial period will be communicated to the patient's primary physician.

# IV. The Treatment Phase of the Study

On Visit 2, the patients will be placed on a cholesterol modified diet. This diet is best de-

scribed as a prudent diet. It is expected to produce some reduction in the serum cholesterol level. In addition, at Visit 5, following completion of the preliminary workup, the patient is randomly assigned to one of two treatment groups: the diet and placebo group or the diet and Cholestyramine group. Cholestyramine is a bile acid sequestrant which is expected to achieve an average reduction in serum cholesterol of about 25%. The drug has been used at the University of Iowa and elsewhere for eight years and has been found to be remarkably free of serious side effects. Cholestyramine was approved by the FDA on August 6, 1973. To avoid potential bias, neither the patient nor anyone seeing him in the Lipid Research Clinic will know whether drug or placebo is being dispensed. The patient's lipid levels in the treatment phase are mailed to the Central Patient Registry located in Chapel Hill, North Carolina. and will not be known either to the clinic physicians or the patient's primary physician. The patient's physician will also be requested to refrain from ordering blood cholesterol determinations on patients enrolled in the project to avoid unblinding the study. Should it become important for medical care, the information on a certain patient's lipid studies or treatment can be obtained from the Local Lipid Research Clinic.

# V. Follow-Up Phase

During the follow-up period, which is expected to last five to seven years, the subjects will be seen in the Lipid Research Clinic at two month intervals for blood lipid determinations and screening for side effects. A more extensive out-patient evaluation will be performed every six months and a stress electrocardiogram will be obtained once a year.

# VI. End Points

Primary end points in the study are a definite non-fatal myocardial infarction or a definite atherosclerotic heart disease death (fatal myocardial infarction, sudden death). Other response variables include different forms of arterial atherosclerotic disease, either fatal or non-fatal. Atherosclerotic coronary heart disease, arterial peripheral vascular disease and cerebral vascular disease are considered here.

# VII. Safety and Data Monitoring Board

A Safety and Data Monitoring Board will review all the data accumulated during the

study. The board may recommend changes in the design of the study or its premature termination on the basis of toxicity data or whenever a significant difference in end points is found between the control and the treated group. At the end of the follow-up period, based on the findings and conclusions gathered, appropriate treatment of patients in the study will be recommended.

### VIII. Conclusion

We feel this study will decide whether lowering blood cholesterol can reduce the incidence of premature coronary heart disease in patients with hypercholesterolemia. The answer to this question is of vital importance and depending on the results, dietary and/or drug intervention measures on a nationwide scale may have to be considered.

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\$300,000 GRANT... Early detection of breast cancer will be main thrust of a research project to begin in 1974 at Iowa Lutheran Hospital in Des Moines. Program will be financed by a

\$300,000 grant from the American Cancer Society, its Iowa Division, and the National Cancer Institute. The project will be directed by Donald C. Young, M.D.



# Disability in Iowa

HOMER E. WICHERN, M.D. Des Moines

In the social security disability program a person under 65 can get monthly benefits if he has a physical or mental impairment which has kept him from working for a year or more, or is expected to prevent him from working for at least that long. This article seeks to show how Iowa compares with other states in its participation in the disability program.

The social security disability program is the nation's largest, covering over 96 million workers and their dependents. Currently, over 1.8 million workers and 1.4 million dependents are receiving disability benefits at the rate of almost \$5 billion a year.

In Iowa, according to the most recent program figures, 19,074 disabled workers are collecting \$3,431,505 a month in benefits. In addition, 3,614 spouses of disabled workers and 10,706 children of disabled workers are receiving totals of \$208,672 and \$575,990 a month, respectively.

A typical year and the latest one for which complete figures are available is 1968; in 1968 3,754 disabled workers in Iowa began to receive benefits, out of 330,783 new beneficiaries nationwide. In Iowa, 2,863 of these newly disabled workers were men, and 891 were women, compared with 246,442 men and 84,341 women across the country.

Nationwide, 86% or 212,061 of male newly disabled workers were white, and 12.8% or 31,663 were black. The remaining are classified as "Other."

Of female newly disabled workers, nationwide, 84.7% or 71,472 were white, and 14.6% or 12,291 were black.

Diseases of the circulatory system comprised the largest diagnostic group across the country, followed by diseases of the bones and organs of movement, and mental, psychoneurotic, and personality disorders. This pattern is not followed in all states. Table 1 compares the frequency of diagnostic groups in Iowa and the entire United States.

Arteriosclerotic heart disease, including coronary disease, was Iowa's most prevalent primary diagnosis, accounting for 525 cases. Iowa's other most common primary diagnoses were schizophrenic disorders, with 168 cases; emphysema 322; osteoarthritis and allied conditions 148; displacement of intervertebral disc 116; cerebral hemorrhage 162; rheumatoid arthritis and allied conditions 140; certain and unspecified hypertensive heart disease 65; diabetes mellitus 99; and pulmonary tuberculosis 31.

The disability rate for Iowa was 539 per 100,000 population. The U. S. disability rate was 626 per 100,000.

Iowa's circulatory disease rate was 115, compared to the nation's 153.

The emphysema rate in Iowa was 46, in the nation 31. The schizophrenia rate in Iowa was 24, in the nation 39. The diabetes rate in Iowa was 14, in the nation 15.

### DETERMINING DISABILITY

The term "disability" under social security means inability to work because of a physical or mental impairment that has lasted—or is expected to last—at least 12 months, or is expected to result in death. Thus, benefits can be paid to people having nonpermanent impairments resulting from accident or illness as well as to those with chronic medical conditions.

To help simplify and speed the processing of disability decisions and to insure uniform treatment of all applicants no matter where they live, medical evaluation criteria have been developed with the aid of practicing physicians, medical organizations, and the Medi-

Dr. Wichern is chief medical consultant, Rehabilitation Education and Services Branch, Iowa Disability Determination Unit, Social Security Disability Program.

TABLE I

# SOCIAL SECURITY WORKER DISABILITY ALLOWANCES (1968) DIAGNOSTIC GROUPS

Diagnostic Group	U. S	3.	IOWA		
Total	330,783	100.0	3,754	100.0	
Infective and parasitic diseases	10,360	3.1	53	1.4	
Neoplasms	36,560	11.1	480	12.8	
Allergic, endocrine system, metabolic, and nutritional diseases	11,359	3.4	140	3 <b>.</b> 7	
Mental, psychoneurotic, and personality disorders	41,894	12.7	430	11.5	
Diseases of the nervous system and sense organs	41,758	12.6	515	13.7	
Diseases of the circulatory system	80,906	24.5	802	21.4	
Diseases of the respiratory system	22,635	6.8	377	10.0	
Diseases of the digestive system	7,806	2.4	81	2.2	
Diseases of the bones and organs of movement	43,677	13.2	516	13.7	
Accidents, poisonings, and violence	25,319	7.7	257	6.8	
Other	8,509	2.6	103	2.7	

cal Advisory Committee to the Social Security Administration.

The evaluation criteria describe, in terms of symptoms, signs and laboratory findings, medical conditions that reflect the level of severity that would prevent most people so impaired from working for a year or longer. These criteria are constantly being refined to reflect advances in medicine and to take into account disability program experience.

### REFERRING PATIENTS

Iowa physicians can help persons who might possibly be entitled to benefits by suggesting that they phone the nearest social security office for further information. Your suggestion may aid the individual in obtaining urgently needed funds.

Monthly benefits range from \$84.50 to \$354.50 for a disabled worker. If there are other dependents, family benefits range from \$126.80 to \$620.40. In addition, under the Social Security Amendments of 1972, Medicare protection will be extended to disabled beneficiaries. Starting July 1, 1973, people who have been entitled to social security disability benefits for more than two years will be eligible for hospital and medical insurance under Medicare.

You can help patients refer themselves by displaying copies of the leaflet "Disabled? Find Out About Social Security Benefits" (SSA-73-10068) in your reception area. Leaflets and dispensers may be secured from local social security offices.

# Angiomyolipoma of the Kidney: Report of Two Cases Studied Angiographically

STEVEN H. CORNELL, M.D., and ROBERT A. BOLDUS, M.D. lowa City

Renal angiomyolipomas were discovered in two patients, one with and one without tuberous sclerosis. The clinical, radiographic and angiographic findings are described.

ANGIOMYOLIPOMA OF THE KIDNEY, also called renal hamartoma, is a rare neoplasm seen mostly in persons with tuberous sclerosis. Less than 200 cases have been reported and most of these have been discovered at post mortem examination. The correct diagnosis has seldom been made preoperatively.

Two patients with renal angiomyolipoma have been studied at The University of Iowa College of Medicine with angiography in addition to excretory urography and retrograde pyelography. One patient with tuberous sclerosis had severe hemorrhage into the tumor and angiomyolipoma was suspected prior to surgery. The other patient had no manifestations of tuberous sclerosis and the correct diagnosis was made only after microscopic examination of the specimen.

### CASE REPORTS

Case 1: A 28 year old man was transferred to The University of Iowa Hospitals with gross hematuria and a painful expanding mass in the right flank. He received two units of blood at his local hospital for shock. A diagnosis of tuberous sclerosis had been made at age 7 because of mental retardation, convulsions, in-

tracranial calcifications and adenoma sebaceum. The convulsions were controlled with medication and the patient did well until he was 17 when an episode of right flank pain and gross hematuria was experienced. The evacuation of blood clots from the renal pelvis was followed at that time by a retrograde pyelogram which demonstrated a greatly distorted collecting system and suggested a diagnosis of renal hamartoma. The bleeding cleared after two weeks of treatment with an indwelling ureteral catheter. Except for one other episode of hematuria which subsided spontaneously, the patient had no further difficulty until the present episode.

The positive findings on physical examination were a blood pressure of 160/100, adenoma sebaceum of the face and a mass in the right flank and abdomen extending from the rib cage to the iliac crest. The urine was grossly bloody. The excretory urogram revealed impaired function on the right with the renal collecting system and ureter displaced medially by a large homogeneous mass. No abnormalities of the left kidney or ureter were detected. An aortogram done the same day demonstrated upward displacement of the hepatic and right renal arteries by a large mostly avascular mass with some abnormal blood vessels in its lower portion. A small amount of functioning renal parenchyma could be seen superiorly. In addition, the vessels in the upper pole of the opposite kidney had an abnormal appearance highly suspicious of neoplasm (Figures 1 & 2). A right nephrectomy was done the same day and a large hematoma was found within Gerota's fascia. The pathologist reported angiomyolipoma of the kidney with extensive hemorrhage. The patient's urine became free of blood and he was discharged in good condition 11 days after the operation.

Case 2: A 59 year old woman fell to the ground one month prior to being seen at The

Dr. Cornell is a professor in the Department of Radiology at The University of Iowa College of Medicine, Dr. Boldus was a resident in the Department of Urology when this paper was prepared and is now in private practice in Sioux City.



Figure 1. Case 1. Renal arteriogram: The hepatic and right renal arteries are displaced upward by a large mass. There is suggestion of a neoplasm in the upper pole of the left kidney (arrows).

University of Iowa Hospitals. After the fall she became anxious and depressed with frequent crying spells and complained of unsteady gait. A cyst had been removed from her left kidney 20 years previously and she had been under medical management for hypertension. There was no history of fever, chills, hematuria or dysuria. Examination at the time of admission revealed the patient to be confused and disoriented. She had a wide based gait and her blood pressure was 190/120. Excretory urogram, nephrotomogram and retrograde pyelogram demonstrated some deformity of the left collecting system with suggestion of a mass in the lower pole of the kidney. No abnormalities were present on the right. An abdominal aortogram revealed distorted vessels with areas of puddling and neovascularity over the area of the left lower pole (Figures 3 and 4).

The patient also had bilateral carotid arteriography and a left temporoparietal subdural hematoma was found. This was evacuated and the patient's neurological condition improved considerably. One month after evacuation of the subdural hematoma a left nephrectomy was done with removal of a large neoplasm which had the appearance of a carcinoma. However, the pathologist reported an admixture of mature adipose tissue, smooth muscle and hyalin-



Figure 2. Case I. One second later the upper pole of the right kidney is opacified. The bulk of the right sided tumor is avascular but there are some abnormal appearing vessels with small aneurysms in the lower part of the mass.

ized and thickened blood vessels. Many of the blood vessels were surrounded by interlacing bundles of smooth muscle with similar bundles scattered in the adipose tissue. The appearance was considered to be characteristic of angiomyolipoma. The patient was discharged two weeks postoperatively in good condition except for some persistent confusion and disorientation.

### DISCUSSION

Renal hamartomas are said to occur in 40-80% of patients with tuberous sclerosis.2 They are frequently bilateral, multiple and mostly asymptomatic, being discovered at post mortem examination. They may however compress the renal collecting system and give rise to infection, pain or hematuria. Sometimes they present as an asymptomatic abdominal mass, whereas in other cases an acute emergency occurs due to massive hemorrhage. The tumors range in size from one to 20 cm in diameter. Histologically, they are composed of fat, smooth muscle and imperfectly formed blood vessels. Although the smooth muscle may exhibit cellular pleomorphism and mitoses characteristic of malignancy, metastases have not been reported and the tumor is therefore considered to be benign.<sup>3</sup> Angiomyolipomas occurring in pa-



Figure 3. Case II. Renal arteriogram: There is dilatation of the left upper renal artery and beginning visualization of distorted blood vessels.

tients without tuberous sclerosis are usually solitary but otherwise identical to those in persons with tuberous sclerosis. They are most commonly found in women between 50 to 70 years of age.

On excretory urography and retrograde pyelography the findings are those of a renal mass which may be entirely within the kidney or protrude from it with varying deformity and compression of the pelvis and calyces. Very large tumors may displace adjacent viscera. Occasionally, the nature of the neoplasm may be suspected because of collections of fat producing areas of radiolucency on the radiographs.<sup>4</sup>

As of January 1971 only 14 cases had been studied angiographically.1 Tumors with extensive neovascularity believed to be indistinguishable from carcinoma have been described by several authors.<sup>5-9</sup> The response of the blood vessels to injection of epinephrine into the renal artery was found by Palmisano to be the same as in the tumor vessels of carcinoma. 10 On the other hand, Viamonte<sup>11</sup> thought that the angiographic appearance of angiomyolipoma was distinguishable from that in carcinoma. He described numerous outpouchings from the renal arterial branches resembling berry aneurysms and a lack of rapid arteriovenous shunting. Khilnani et al<sup>5</sup> also described sacculations as well as an "onion peel" appearance



Figure 4. Case II. One second later numerous irregular puddles of contrast material are seen in a poorly defined left sided mass. The right kidney has a normal appearance.

in the venous phase and a generally less disorganized appearance than in carcinoma.

Our first patient had tuberous sclerosis and the diagnosis of right renal hamartoma had been suspected several years before the hemorrhage into the neoplasm. The renal arteriogram was done to assess the status of the opposite kidney in which there is a suggestion of a relatively avascular lesion of the upper pole (Figure 1). On the right a few abnormal vessels with aneurysmal dilatations are visible in the lower part of the mass (Figure 2). The neoplasm is not nearly as vascular as many previously described. By way of contrast the neoplasm in the second patient was quite vascular, showing areas of tumor vessels and puddling of contrast material similar to that in carcinoma (Figure 4). The diagnosis of angiomyolipoma was not made prior to pathological examination.

In our experience there is considerable variation in the vascularity of renal carcinoma, from minimal neovascularity to extensive bizarre and disorganized vessels. There seems to be a similar variation in angiomyolipomas and we do not believe that a specific diagnosis can be made on the basis of the angiographic appearance.

# REFERENCES

The references noted in this article may be obtained from either the authors or the Journal of the Iowa Medical Soci-

# Editorials

M. E. ALBERTS, M.D., Scientific Editor

# YOUR FUTURE

Much has been written about the need for physicians to up-date their medical knowledge to retain membership in the medical societies and to renew licenses to practice medicine. Certainly an attendance roster for a given meeting or lecture offers no assurance the physician actually attended or paid attention to the discussion. An examination, written or oral, cannot be fair—what does a pediatrician know about the surgical treatment of carcinoma of the pancreas? We all know persons who "freeze-up" on examination, yet have good practical knowledge of the subject at hand. Subscriptions to medical journals or medical

digest tapes provide no guarantee that the contents are taken into the brain and absorbed for future recall. Teaching or writing scientific papers implies knowledge and research, but who is to judge?

Perhaps a panel of patients should be formed to judge the physician—but what will they use as the measurement of excellence—good medical practice or smooth talk?

These questions are randomly constructed, but they have a serious connotation. Pressure is building from government, peer groups, and society as a whole to re-evaluate our qualifications to practice medicine. Our medical society, as well as the state licensing board, is tackling these questions. Can fair and effective programs be devised? It concerns you, Doctor; think seriously about it.—M.E.A.

# WHO DOES THE KILLING?

An interesting and informative article appeared in the March 1973 issue of CALIFORNIA MEDICINE. The article, a report of the CMA Committee for Continuing Study of Evolving Trends in Society Affecting Life, is entitled Euthanasia—An Overview for Our Time. It mentions that the classic definition of euthanasia—"painless putting to death" (synonymous with "mercy killing")—has been diluted to include the meaning "to let a person die." The article suggests that "mercy killing" should be described as positive euthanasia, and "letting someone die" as negative euthanasia. The difference is explained in this manner: "In positive euthanasia, the agent of death is another

person, in negative euthanasia, it is the illness."

The semantic mix-up over the meaning of the word euthanasia is unfortunate, for the issue becomes clouded and no one can be sure what another is talking about. And when that happens, changes may occur that become irreversible even before pertinent implications are clearly understood. To let a person die under hopeless circumstances and without heroic lifesustaining measures is nothing new, for it has long been an acceptable philosophical viewpoint that there is no obligation to take extraordinary measures to preserve a hopeless life. Mercy killing, however, is another matter, although the end result is obviously the same, and the distinction is considered superficial by some. Be that as it may, the specter of mercy killing is approaching, and as society wrestles with the concept, the doctor, by some strange

twist of logic, is invariably considered the proper "agent of death."

In this regard, a recent Gallup Poll (reported in the August 13, 1973 issue of the AMERICAN MEDICAL NEWS) asked the following question:

"When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?"

A majority (53%) of those polled responded yes to the question.

It would be instructive if someone would explain why it is taken for granted by so many, as it is by the Gallup Poll and probably by the respondents, that if there is some sort of killing to be done—"mercy killing" in this instance it should be done by a doctor. What is there presumed to be in a doctor's training, or his ethics, that makes him the instrument of destroying life? Can it truly be a generally accepted belief that several years of medical school are necessary to learn how to give an overdose of morphine, or to do an abortion for that matter? Or could it be that a doctor lends a mantle of respectability to what otherwise must be a distasteful and grisly business? The answer is not entirely clear, for there is much contemporary confusion about a doctor's role in today's world—a confusion, incidentally, that seems to be shared by many doctors.

Physicians are not ordained to make people happy, or even to satisfy their wishes, and certainly not to do away with them. The doctor's traditional function—and it cannot be emphasized and repeated too often—is to combat disease and to contribute to the preservation of life. This is historically so true that even on the battlefield the physician is a non-combatant,

there to care for the wounded and to preserve life. Suddenly, though, a change has come. "Abortion reform," by endorsing the "unwanted" concept and by permitting the active destruction of life, has opened a gate. Mercy killing is certain to follow, for anyone who can make a case for abortion can make a better case for mercy killing, and will do so. In this ongoing process, the doctors have been ambushed, for they have been cast in the role of the killer—the instrument of death. Strangely enough, many doctors seem willing to accept this assignment.

The drums are beating. Let us heed the signs. Society may someday permit, even mandate, a sentence of death for the incurable, the old and senile, the insane, the misfit, the unwanted, and any others who might be defined as "non-persons." The morality of such killings, as of abortions, can be argued at length, but we delude ourselves if we do not recognize that their acceptance is nearer today than it was yesterday. Proponents of mercy killing will argue persuasively, the meaning of words will change, and history and tradition will be overlooked. But whatever the morality, and however persuasive the justification, if killing is to be done, the physician should stand aside.

The California Committee recommends that a panel of community representatives make these individual life-or-death decisions if or when they arise, and if death is decided, the physician withdraw from the case. "It is imperative," the Committee states, "that medicine maintain its role of healer rather than executioner."

That viewpoint is worth adopting, that advice worth taking.—Daniel F. Crowley, M.D.

# QUIET-HOSPITAL ZONE

A common admonition to traffic is that quiet must be maintained in the vicinity of a hospital. What of the hospital's internal environment? There is the constant traffic in the halls, the ringing of telephones, the conversations among personnel and visitors, the paging of physicians, and in certain areas, the noise of ventilators, monitors and pumps.

A recent report¹ considers possible health hazards as a result of noise in hospitals. Measurements were made of sound pressure levels inside infant incubators, in a 17-bed surgical recovery room, and in a 7-bed acute care unit. Consideration was given to the noise levels, the sources of the noises, and the treatment given to the patient. Though the noise intensity levels were not known to be hazardous, it was noted that when ototoxic drugs were given to the patient at the time, possible deleterious

effects could occur. What of the infant on ventilatory assistance, monitor beeping, and receiving kanamycin—combined with the usual noise in a busy intensive care unit? Personnel in the unit become unaware of these noises because it is a way of life, but to the occasional visitor the noise level is readily apparent. Will there be long-term effects on the patient? Is our machine-world enveloping us in a blanket

of noise that gives no warning? I believe this report should serve as a warning. Peace and quiet are valuable attributes. Patients deserve that consideration, in addition to antibiotics and excellent medical and surgical care.—M.E.A.

1. Falk, Stephen A. and Woods, Nancy F.: Hospital noise: levels and potential health hazards. New Eng. J. Med. 289:774-780, 1973.

# 'SUFFER THE LITTLE CHILDREN'

The fate of the severely retarded or deformed infant is often placed in our hands. These crucial decisions are exceedingly difficult, and we sometimes find ourselves in disagreement with the ultimate wishes of the parents. How can decisions be made that are equitable to all concerned?

Two very excellent papers appear in the October 25, 1973 issue of the New england Journal of Medicine. Shaw¹ discusses the dilemma of "informed consent" with children, when parents decide to withhold consent for treatment of infants who are severely afflicted. The parents may refuse treatment because of religious beliefs, or out of fear or ignorance. Shaw believes that all rights are not absolute all the time; further, that all rights are imperfect and may be set aside if human need requires it. This ethic considers quality of life as a value that must be balanced against a belief in the sanctity of life. Should the decision for

heroic measures be for the physician alone to make?

Duff and Campbell<sup>2</sup> consider moral and ethical dilemmas in the special-care nursery in relation to withholding treatment of infants with multiple anomalies and where the prognosis for meaningful life is extremely poor or hopeless. How does one equate withholding surgery for intestinal obstruction in an infant obviously affected with other disorders which preclude an existence other than being a helpless ward of society—mentally as well as physically? Such decisions cannot be based on medical criteria alone. Society must have a voice in the matter. Proper guidelines must be delineated which will be free of legal entanglements.

These two discussions underscore the agonizing decisions in which we must share. We have to look squarely at the problem from a professional position and as members of society. To look the other way is to shirk the responsibility we have for the little ones.—M.E.A.

 Shaw, Anthony: Dilemmas of "informed consent" in children. New Eng. J. Med. 289:885-890, 1973.
 Duff, Raymond S., and Campbell, A. G. M.: Moral and

 Duff, Raymond S., and Campbell, A. G. M.: Moral and ethical dilemmas in the special-care nursery. New Eng. J. Med. 289:890-894, 1973.

# PEDIATRIC CONFERENCE APRIL 25-26

The 18th annual Pediatric Conference of the Raymond Blank Memorial Hospital for Children will be April 25 and 26 in Des Moines. Site of the conference will be the Iowa Methodist School of Nursing.

Conference speakers will include William Berenberg, M.D., professor of pediatrics, Harvard Medical School; Giulio J. Barbero, M.D., professor and chairman, Department of Pedi-

atrics, University of Missouri; William Glasser, M.D., president and founder, Institute of Reality Therapy, Los Angeles; and James Taylor, M.D., associate professor, Department of Pediatrics, University of Iowa.

Conference registration fee is \$40, which includes luncheon and banquet; one-day registration is \$20. Registration fee is waived for interns and residents. Further information is available from L. A. Wintermeyer, M.D., Iowa Methodist Hospital, 1200 Pleasant Street, Des Moines, Iowa 50308.

# Doctor's Business

by LARRY E. LEAVERTON

#### STANDARD INSURANCE FORMS

The announcement that a new Uniform Insurance form is now available through the American Medical Association should be good news to all physicians. With more than half of medical services in most offices covered by some type of third party payment requiring a claim form, a real problem has existed in coping with the multitude of forms. The growth of the health insurance industry and governmental coverage, and the broadening of policy provisions has brought about many different types of forms. The forms are complicated, frequently confusing, time consuming, and in some opinions, request dubious information. On many forms the same information is requested but in different places on the form.

This new standard form has been developed jointly by the American Medical Association, Health Insurance Council, Medicare, Medicaid, Bureau of Health Insurance, California Medical Association, Medical Group Management Association, National Association of Blue Shield, CHAMPUS, and the Society of Professional Business Consultants. This uniform claim form is designed to satisfy the needs of most health organizations and agencies, reduce the total costs of claim processing, and simplify physician reporting and third party processing without impairing systems and efficiencies.

Advantages of a uniform claim form are obvious. The medical assistant responsible for

the filing of claims becomes familiar with the location of questions and knows exactly where to put the data. Much valuable time has been lost analyzing the various claim forms to determine what information is needed. Prompt filing of claims help prevent collection losses. Time savings in this department will hopefully reduce office overhead. The form is flexible enough for completion by typewriter, computer or by hand. Where duplicate or triplicate copies are necessary, carbons or copy machine copies can be easily provided as a service to the patient.

As with any effort on a project of this magnitude, there had to be compromises. The private insurance industry needs information not consistent with, or comparable to that of the governmental agencies. Some critics of the form say there are too many elements. The form contains 34 elements separated into two major sections—patient information and physician information. The patient and insured section contains 11 data elements and two spaces for signatures. The physician or supplier information consists of 21 elements. There are, however, few circumstances that would require all of these to be completed.

In addition to the use of a standard insurance form, we have other suggestions for the orderly processing of insurance and third party claim forms:

• Develop an insurance specialist within the office—one who is familiar with the information needed. One who can field the many questions asked by patients. One who is fast and efficient in her work. This will speed up the time in filing. What is a reasonable time lapse be-

(Please turn to page 39)

Mr. Leaverton is Director of Research and Development for Professional Management Midwest.

# **Medical Assistants**

by TENORA MEYER, CMA

#### JEANNE GREEN RE-ELECTED

Jeanne D. Green, CMA, Davenport, was reelected trustee of the American Association of Medical Assistants at the recent national convention. Jeanne has been an AAMA trustee since 1970 and her new term will expire in 1975. She is medical assistant to James F. Bishop, M.D. She was the founding president

of the Scott County AAMA Chapter and has been active in the chapter for 15 years. She has served as state president, vice-president, secretary and parliamentarian.

Marian G. Cooper, CMA, Pittsburgh, Pa., was installed as national

AAMA president on October 26. Officers elected at the convention included Betty Lou Willey, CMA, Port Huron, Michigan, president-elect; Laura L. Lockhart, CMA, Akron, Ohio, Vice President; and Dorothy Hartel, Maryland, Secretary-Treasurer.

#### ENGLAND AND CANADA REPRESENTED

More than 1,000 AAMA members attended the national convention. Medical assistants from England and Canada were present. A work exchange program involving British and American medical assistants was announced. It was recommended the exchanges be for three months.

Members attending from Iowa included Winnie Donovan, CMA, Sally Gesink, Florence Hansen, Frances Hansen, CMA, Martha Haverkamp, JoAnn James, Tenora Meyer, CMA, Mildred Roth, Betty Ehlert, CMA, Lucille

Holmes, Shirley Muehlenthaler, Florence Henry, Betty Kelley, Marian Little, Marcine Sanders, CMA, and Jeanne Greene, CMA.

#### AMA GIFT

Dr. Robert B. Hunter, special liaison from the AMA Board of Trustees, spoke at the October 23 luncheon and announced a gift of \$25,-000 from AMA to the AAMA educational program.

#### COMPUTER DEMONSTRATION

A computerized patient interview was demonstrated by Medi-Tech of Indianapolis, Indiana, via telephonic hookup. A standard IBM Information Display System which has a cathode ray terminal similar to a TV screen is used to acquire the data. The patient sits at the screen and responds to questions by pressing keys on a keyboard. If the patient does not understand the question, the computer can further explain or restate the question. Because he can erase and correct an answer as well as decide when he is ready for the next question, the patient has control over the computer. When the patient finishes the interview, the medical history is recorded and returned to the physician in narrative form. Interval updating is possible in this system as it can add to or modify the original.

#### PROJECT CONCERN

Dr. Jim Turpin described Project Concern as an organization established in 1961 to provide a full range of medical and dental services to impoverished peoples abroad and in the United States. It provides treatment annually to more than 500,000 people in Hong Kong, Ethiopia, South Vietnam, Mexico, New Mexico, and in the Appalachian section of Central Tennessee. James Turpin and his wife, Martha Turpin, both M.D.'s, are the founders of this organization.

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

# ETHICAL GUIDELINES SERVE MEDICAL PROFESSION

THE JUDICIAL COUNCIL is a most important organizational component of the Iowa Medical Society. Its membership includes 12 physicians from across the State. The Council's duties are described officially in the Society's Articles of Incorporation. Here's what they say in part:

"The Judicial Council shall have supreme charge of all questions of ethics and discipline of members and shall be the Board of Censors of this Society. As such it shall receive, hear, and decide finally for this Society all appeals from the decisions of component societies. It shall have and exercise original jurisdiction over and decide finally for this Society all questions of ethics, discipline, or rights to membership in component societies or this Society submitted to it by a physician, a member, the general meeting, the House of Delegates, the Board of Trustees, or the Grievance Committee. . . . All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Judicial Council without debate...."

Ethics is the key word in this job description. A precise definition of the word is difficult. Ethics pertain to moral action or duty, they constitute a sort of pattern for human behavior; or, in other words, as most realize, they exist as a code for professional conduct.

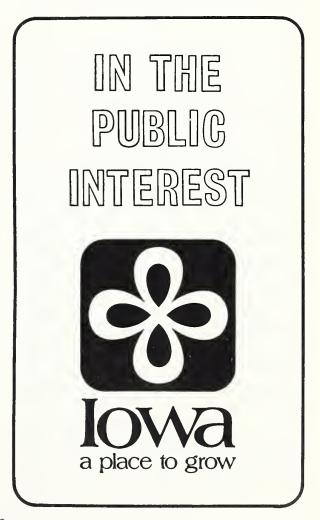
The earliest written code of ethical principles for medical practice was conceived by the Babylonians around 2500 B.C. That document, the Code of Hammurabi, set forth in considerable detail for that era of history the nature of conduct demanded of the physician.

Following after, and more widely known as the ethical instrument for the medical profession, came the Oath of Hippocrates. This brief statement of principles has survived and remains a living and even workable statement of ideals to be cherished by the physician. This Oath had its origin during the period of Grecian greatness, probably in the fifth century B.C. It declares the rights of the patient and appeals to the inner and finer instincts of the physician without imposing sanctions or penalties on him. It continues as an expression of ideal conduct for the physician.

Moving forward into more modern times, the American Medical Association in 1847 adopted a code of ethics based on the 1803 Code of Medical Ethics published by Tomas Percival, an English physician, philosopher and writer. The intent of the AMA Code has remained even though there have been revisions through the years in the interest of clarity.

In 1957, the American Medical Association adopted a 10 section statement of principles which expresses concisely the fundamental concepts contained in the more extensive ethical commentary. This 1957 effort did not replace the existing guides, it was devised rather as a succinct set of principles for basic attention. Here's how they read:

1. The principal objective of the medical profession is to render service to humanity



with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

- 2. Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.
- **3.** A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.
- 4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.
- 5. A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.
- 6. A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.
- 7. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.
- 8. A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.
  - 9. A physician may not reveal the confi-

dences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

10. The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

As stated in the preamble, these principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

In the conduct of its work the Iowa Medical Society Judicial Council makes use of these ethical guides. The 12-member Council meets no fewer than four times per year to review and act on matters referred to it.

In addition, the physician councilors are charged to work independently in their respective districts to organize and guide a positive program for the medical profession. These practitioners (named here) are selected by their physician constituents. They perform a significant task in behalf of the profession and the public. They deserve to be applauded.

# IOWA MEDICAL SOCIETY JUDICIAL COUNCIL

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# About IOWA Physicians

Dr. John W. Berg, recently appointed professor of preventive medicine and environmental health at U. of I. College of Medicine, will direct Iowa Cancer Epidemiology Center established at U. of I. under a \$241,493, one-year contract with the National Cancer Institute. The center will seek to provide information and foster development of programs for indepth studies of cancer surveillance in Iowa. Dr. Berg is the former head of Epidemiologic Pathology Unit of National Cancer Institute, Bethesda, Maryland. He received the M.D. degree at Yale University and served his internship and residency in pathology at New Haven Hospital. In 1963 he was named recipient of Alfred P. Sloan Award in Cancer Research. ... Dr. John L. Hoyt, Creston, is new president of the Union County Heart Unit. . . . Dr. Mohamed R. El-Dieb, formerly of Westfield, Massachusetts, has joined Dr. R. A. Youngman in Cedar Rapids. Dr. El-Dieb received his medical training at Ain Shams University in Cairo, Egypt. Following a residency in internal medicine at the Ain Shams Hospital, he served two years as registrar of the Allergy Clinic in St. Mary's Hospital in London and was a Fellow in Chest Diseases at St. Joseph's Hospital in Toronto, Canada. . . . Dr. P. Thomas McGarvey has joined Surgical and Orthopedic Associates in Waterloo. Dr. McGarvey received the M.D. degree at U. of I. College of Medicine in 1966. He interned at Los Angeles County General Hospital, Los Angeles, California, and completed his residency in general surgery at University Hospitals, Iowa City.

**Dr. Jon Wubbena**, Rock Rapids, and **Dr. J. G. Lavender**, George, lectured recently on coronary care to R.N.'s and L.P.N.'s of Merrill Pioneer Community Hospital in Rock Rapids.

Purpose of session was to acquaint hospital personnel with new coronary care equipment. . . . Dr. Alfredo D. Socarras, Des Moines, recently attended the Tenth International Congress of Neurology in Barcelona, Spain. . . . **Dr. Ronald Flory,** who has practiced medicine in Grundy Center since July 1, left recently to complete a two-year military obligation. Dr. Flory will attend an aerospace medical school at Brooks AF Base for three months and will be stationed for 21 months at Clark AF Base in the Philippines. On completion of tour, Dr. Flory will resume his medical practice with Dr. Patricia Ehrich at the Grundy Medical Clinic. . . . Dr. Charles Argo, Oskaloosa, participated in seminar on child abuse at Vennard College.

Dr. R. S. Gerard, Waterloo, recently presented a \$1,000 scholarship to Stanley E. Peterson, senior medical student at U. of I. College of Medicine, from the International College of Surgeons. Dr. Gerard is the ICS State Regent. The scholarship to Dr. Peterson is for study of orthopedic surgery in 1974 at the Lorenz-Bohler Krankenhaus in Austria. . . . These Iowa physicians have been named Fellows of American College of Surgeons: Dr. Charles E. Schaefer, Carroll; Dr. James R. Flynn, III, Cedar Rapids; Drs. Franklin J. DeRnsso, Ronald J. Hofmann, and William B. Hofmann, Davenport; Dr. Lonis D. Rodgers, Des Moines; Dr. Paul G. Pechons, Dubuque; Drs. Charles J. Kranse, Guy E. McFarland, III, and Wilbur L. Zike, Iowa City; Dr. Ki Taek Song, Mason City; Dr. Edward B. Grossman, Jr., Orange City; Drs. Stnart W. Leafstedt and David G. Paulsrud, Sioux City; and Dr. J. Richard Long, Waterloo.

Dr. Joseph Brunkhorst has joined Drs. Robert W. Dunlay, Thomas C. Graham and Herbert E. Gude, in medical practice in Iowa Falls. A native of Masonville, Dr. Brunkhorst attended Creighton University School of Medicine, interned at Highland General Hospital, Oakland, California, and had a year's residency at Contra Costa County Hospital at Martinez, California. . . . At recent Iowa City workshop on drug abuse and alcoholism, Dr. James Stiles, Cedar Rapids, presented a statement on current problems of drug abuse. . . . Dr. K. V. Shah, of the Clarinda Mental Health Institute, has been named a foundation member of the Royal College of Psychiatrists in the United Kingdom. A court of electors determines those to receive the honor on the basis of training, work experience and responsibilities. . . . Dr. John Lanning, Charles City, who has been providing part-time coverage to Clarksville, closed his office there in September.

Dr. T. J. Michelfelder, Fort Dodge, was recently elected president of Missouri Valley Dermatology Society. Dr. Michelfelder has practiced dermatology at the Kersten Clinic in Fort Dodge since 1955. . . . Dr. J. L. Flood, Denison, has passed Part One of the Certification for American Society of Abdominal Surgeons. . . . Dr. S. B. Hussain, clinical director of Woodward State Hospital-School, is new member of the Ethics Committee of American Association on Mental Deficiency. Dr. Hussain represents division of medicine on committee to establish code of ethics and review reported violations. Established in 1876, AAMD fosters cooperation among those engaged in study, training, treatment, and care of mentally retarded. Dr. Hussain is also medical chairman for Region Eight of AAMD (Iowa, Minnesota, Nebraska, North and South Dakota and Manitoba, Canada).

Dr. Kheir Ghandour, of Shenandoah, has ac-

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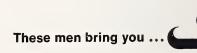
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cepted a position with the Department of Orthopedic Surgery at St. Joseph's Hospital in Chippewa Falls, Wisconsin. Dr. Ghandour has practiced orthopedic surgery in Shenandoah since 1970. . . . Dr. Herman A. Hein, director, Statewide Prenatal Care program, spoke at a recent joint meeting of Wapello County Medical Society and medical staff of Sunnyslope Extended Care Center in Ottumwa. Dr. Hein's topic was "Newborn Care in Nursery." Dr. Hein directs the Muscatine Community Health Center and is an assistant professor in the U. of I. Department of Pediatrics. . . . Dr. Mohammed Badruddoga, has joined the Clarke Medical Clinic in Osceola. Dr. Badruddoga, or Dr. Doja, as he prefers to be called, is a 1961 graduate of Dacca Medical College in Bangladesh, Pakistan. He served his surgical residency at Highland Park General Hospital in Detroit, Michigan. Dr. Doja is a member of American Board of Surgery, Fellow of the Royal College of Surgeons in Canada and member of International College of Surgeons.

Dr. Gene Egli, Fairfield, was guest speaker at recent meeting of Fairfield Business and Professional Women's Club. Dr. Egli's topic was "Can We Afford Good Health?" . . . Dr. Gerald F. DiBona, associate professor of medicine at U. of I. College of Medicine, presented a recent slide-lecture on "Drug Metabolism and the Kidney," at Grinnell College. . . . Dr. Michael Croxdale, Bloomfield, gave a presentation on skin cancer at a local meeting sponsored by the educational division of Davis County Cancer Society. . . . Dr. N. L. Saxton, Oskaloosa, has closed his medical practice to become an associate professor in the Department of Family Practice at Texas Tech University, Lubbock, Texas. Dr. Saxton's first two years will be devoted primarily to medical students' activities. Subsequently, he will be associated with the residency program in Lubbock, Texas, which is to be the central point for family practice residency programs in three other Texas cities. . . . Dr. James Carr, New Hampton, spoke at recent meeting of community's Booster Club. Dr.

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#### THE BANKERS LIFE



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Carr discussed the medical approach to high school athletics.

Dr. Joseph C. Torbert will join Dr. J. P. Trotzig at Akron this June. Dr. Torbert is completing a family practice residency in Omaha, Nebraska. . . . Dr. Jack Moyers was re-elected vice-president for scientific affairs of the American Society of Anesthesiologists. Dr. Moyers is professor and head of the Department of Anesthesia at U. of I. College of Medicine. . . . Dr. John Huston, Cedar Rapids radiologist, served two-month tour of duty on the hospital ship Hope at Maceio, Brazil. This is Dr. Huston's third tour with the Hope. He has been to Ecuador and Colombia. . . . Dr. J. B. Schaaf, Sidney, participated in recent diabetic education program at Grape Community Hospital. Dr. Schaaf's topic was "What Is Diabetes?" . . . Drs. Bhasker J. Dave and Nestor Pangilinan, of the Independence Mental Health Institute, have been named diplomates of American Board of Psychiatry and Neurology. Dr. Pangilinan is assistant clinical director and Dr. Dave is medical director of the alcohol unit. Dr. Helen Halbert has joined the Independence Mental Health Institute staff. A graduate of the Medical College of Pennsylvania, Dr. Halbert served her psychiatric residency at Seaton Psychiatric Institute in Baltimore and practiced in Davenport. Board certified in psychiatry, she most recently was associated with the Cherokee Mental Health Institute. . . . Dr. John Tyrrell, Manchester, and Dr. H. A. Gearhart, Hopkinton, were panel participants in recent health services forum in Manchester. Dr. Tyrrell spoke on area-wide health planning, and Dr. Gearhart discussed physician recruitment in rural areas.

#### **DEATHS**

Dr. A. J. Wentzien, 67, retired Tama physician, died October 19 at his home. Dr. Wentzien began the practice of medicine in Tama in 1932 and retired in 1971. A 1930 graduate of U. of I. College of Medicine, Dr. Wentzien was a member of Iowa Medical Society and American Medical Association.

Dr. J. M. Lloyd, 80, Washington physician for 40 years, died October 6 at Washington County Hospital. Dr. Lloyd received the M.D. degree at U. of I. College of Medicine in 1926. He was a past president of Washington County Medical Society; 50-year member of Masonic Lodge; member of Iowa Medical Society and American Medical Association.

**Dr. V. S. Downs**, 75, retired Ottumwa internist, died September 27 at his home. A 1927 graduate of U. of I. College of Medicine, Dr. Downs began his practice of internal medicine in Ottumwa in 1941. He was a World War I veteran; 50-year member of Masonic Lodge; and served as president of Ottumwa Hospital medical staff in 1953.

Dr. E. E. Munger, Jr., 75, Spencer, died October 4 in Tucson, Arizona. Dr. Munger practiced medicine in Spencer for 40 years prior to moving to Tucson four years ago. Dr. Munger received the M.D. degree at Rush Medical College in 1924 and served his internship and residency at St. Luke's Hospital in Chicago. He was a member of Iowa Medical Society, American Medical Association, and an honorary member of the Spencer Municipal Hospital medical staff.

#### THE DOCTOR'S BUSINESS

(Continued from page 31)

tween presentation of the form and filing? One week, in our opinion. We have seen offices where forms are piled up for months.

- The full cooperation of the physicians in the office is necessary such as full information on the patient's history, etc. In many cases the medical assistant responsible for insurance claim filing is falsely blamed when the fault lies elsewhere.
- The full cooperation of the patient is also important in providing the necessary information.
- Give full and complete information on the claim form. Many claims are held up unnecessarily because of follow-up requests. Be explicit about procedures or services rendered.

If after trying all of the above suggestions, a backlog of forms is still present, additional help may be necessary. Just as a practice grows and more space and assistants are necessary, the increase in greater coverage by more patients requires more help to get the task done.

The new uniform claim form may not be the entire final answer, but it appears to be a step in the right direction.

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Prouty Company
Roche Laboratories 2, 3, 18B, 18C, 43, 44
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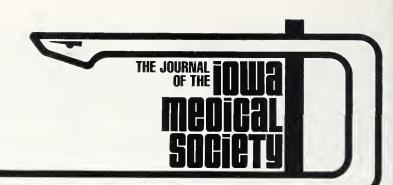
Precautions: If combined with psychotropics or anticonvul-, consider carefully pharmay of agents employed; drugs as phenothiazines, narcotics, turates, MAO inhibitors and antidepressants may potentia action. Usual precautions ated in patients severely deed, or with latent depression, the suicidal tendencies. Observe precautions in impaired renal

or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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VOL. 64 No. 2 FEBRUARY, 1974

TABLE OF CONTENTS		Iowa Medical Miscellany	50
Hospital Governing Board and Medical Staff Relationships		The Question Box	58
Betty Jane Anderson, J.D.	52	In the Public Interest	70
Patient Care Evaluation in an Iowa Hospital		Educationally Speaking	72
John Murphy, M.D., Charles Linden, M.A., and Richard Caplan, M.D.		State Department of Health	74
Cancer in Iowa—1970 John W. Berg, M.D.		Medical Assistants	76
	65	About Iowa Physicians	78
EDITORIALS		Deaths	82
Annual IMS Scientific Session	68		
Hospital Automation	68	MISCELLANEOUS	
On Writing Editorials	69	Quality Assessment Consultation Program	64
SPECIAL DEPARTMENTS		Continuing Education Courses and Con-	
President's Page	49	ferences	64

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		1

Address all communications to the Editor of the Journal, 1001 Grand, West Des Moines, Iowa 50265.

Postmaster, send form 3579 to the above address.

# President's Page

"It is my pleasure to invite you to come to Iowa City in the Spring to take part in the 1974 Annual Scientific Session of the Iowa Medical Society. The program will run from Thursday afternoon to Saturday noon, April 18, 19, 20."

This opening paragraph from my January letter to all IMS members bears repeating here. Most of us plan our schedules as far ahead as possible. Thus, we'd like to be sure you are aware of these April dates, as you contemplate your schedule. Obviously, we would like to have you as a participant in the Society's 1974 scientific sojourn to Iowa City.

We assure you an outstanding continuing medical education experience. It'll be a diversion from the routine lecture/listen format.



Roundtable discussions, interdisciplinary workshops, departmental open houses, etc., are planned during the three days. Here's a sampling of the topics to be covered: acute allergic reactions, peripheral vascular disease, coronary arteriography and surgery, hypertension-renal disease, control of GI bleeding, medical and surgical care of obesity, biomedical ethics, etc.

Cultural and entertainment activities are planned for you and your wife at the Art Center, Hancher Auditorium, the new Medical Library, etc.

You'll be receiving further details soon. I personally hope you will plan to be with us April 18, 19, 20.

Sincerely,

Rubin Flocks, M. D.

Rubin Flocks, President

# IOWA Medical Miscellany

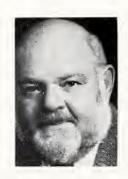
1974 SCIENTIFIC SESSION... Program planning for the 1974 IMS Scientific Sessions is virtually completed. The sessions will open Thursday afternoon and continue to Saturday noon (April 18-20) in Iowa City. The topflight continuing medical education program will follow a

varied format. Included are clinical open houses, interdisciplinary workshops, small group confabs with faculty, etc. Robert Marston, M.D., former director of the National Institutes of Health, will be an opening day speaker. A complete program will be published as part of the March JOURNAL.

NOMINATING ACTIVITIES... Selection of the 1974 Nominating Committee is in process with district caucuses continuing into March. Nominating Committee will meet at 2 p.m., Sunday, March 31, at IMS Headquarters to choose 1974-75 candidates for office. This meeting is open to interested members.

AREA DESIGNATION . . . Final approval is expected shortly for the PSRO area designations announced by HEW in late December. The profession's reaction has been mixed across the country. States divided into several PSRO areas have been more apt to criticize the HEW proposals. Iowa is one of 25 single state PSRO areas. AMA has requested a 90-day delay to file comments in support of medical organizations seeking changes in their area designations.

ELECTED... Marvin H. Dubansky, M.D., Des Moines, has been elected recently to the Board of Directors of the Iowa Foundation for Medical Care. Dr. Dubansky succeeds John H. Kelley, M.D., Des Moines, as a Foundation director for District 5. Dr. Kelley was earlier named to the Iowa Medical Society Board



of Trustees to succeed the late Jerome F. Paulson, M.D., and therefore continues as a Foundation Board member. Dr. Dubansky is an orthopedic surgeon in Des Moines and is the current president of the Polk County Medical Society.

HOUSE REMINDER . . . For the second year, the Annual Meeting of the IMS House of Delegates will be apart from the Scientific Sessions. The House will meet in Des Moines May 11-13.

FAMILY PRACTICE . . . Physicians in residency training in Iowa to become family practitioners have increased from six in 1971 to 47 at the end of 1973. Existing community hospital residency programs are operational at Mercy Hospital, Iowa City; Broadlawns-Polk County Hospital, Des Moines; and St. Luke's-Mercy Hospitals, Cedar Rapids. New programs are starting at Iowa Lutheran Hospital, Des Moines, and St. Joseph Mercy Hospital, Mason City. The 11-member Iowa Family Practice Education Advisory Board has approved Sioux City, Davenport and Waterloo as sites for new programs. Forecasts are that 138 to 156 residents will be in training by 1976 with a "graduation" potential of 52 a year.

REPORT... Late 1973 conference of IMS, Blue Shield and Iowa Foundation for Medical Care representatives was reported to the Society's Executive Council January 24. Report covered use of AMA Current Procedural Terminology (CPT) by Iowa physicians, possible statewide determination of customary charges and feasibility of filed fee schedules.

**SPECIALTY MEETING...** Briefing session for officers of Iowa medical specialty organizations was offered January 23 at IMS Headquarters. Topics discussed included PSRO implementation, pending legislation, procedure coding and nomenclature, etc.

ALCOHOLISM . . . IMS Committee on Alcoholism met January 10 with State Senators Minette Doderer and Tom Riley to receive briefing on legislative proposal dealing with detoxification.

**CHIROPRACTIC...** Study commissioned by the State Board of Health on chiropractic was submitted to the Board in January. Special study committee included three chiropractors, two physicians and several others. The committee indicated (by vote of 6-2) that it is unable to recommend any change in the Chiropractic Practice Act at this time.

STUDY STUDY... IMS Committee on Delivery of Health Services met January 10 to evaluate draft of the State Comprehensive Health Plan devised by Office of Comprehensive Health Planning. OCHP is assigned to structure and maintain a state plan on an ongoing basis. It has sought input from various sources.

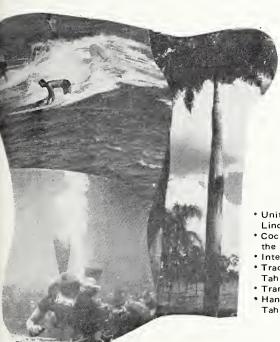
**DRUG ABUSE...** Society's Committee on Drug Abuse met at IMS Headquarters January 17 to consider matters of importance.

STAFF RELATIONS . . . A special presentation on hospital and medical staff relations was made to the IMS Executive Council January 24 by B. J. Anderson of the AMA Legal Department. Article by Attorney Anderson appears in this issue of the IMS JOURNAL.

**AUXILIARY EVENT . . .** Annual Legislative Brunch sponsored by the Woman's Auxiliary for wives of Iowa lawmakers occurred January 30 at IMS Headquarters. Auxiliary members visited the Statehouse during the afternoon to view the legislative process.

NAMED... John Tyrrell, M.D., Manchester, and Paul Seebohm, M.D., Iowa City, are chairman and vice-chairman, respectively, of the Iowa Regional Advisory Group. This 40-member unit provides guidance to the Regional Medical Program.

**LEGISLATOR DINNER...** The Iowa Health Council hosted members of the General Assembly February 5 at traditional dinner. IMS is one of nine organizations which comprise the Council.



# TAHITI-\$498 - APRIL 18-24

Dear Iowa Medical Society Members:

The Nebraska Chapter of Family Physicians and The Nebraska Medical Association would like to invite each of you to join us for our Annual Scientific Session in Tahiti.

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# Hospital Governing Board and Medical Staff Relationships

BETTY JANE ANDERSON, J.D. Chicago, Illinois

Hospital medical staffs are challenged to be more than a group of individual physicians. They have an obligation to act productively and responsibly. Relations with governing boards must be firm and in the nature of a partnership.

DURING THE PAST FEW YEARS, the number of disputes between hospital governing boards and organized medical staffs has been increasing at an alarming rate. The basic issue in these disputes is relatively simple: are hospitals or physicians primarily responsible for the care and treatment of patients? Will the patient of tomorrow look to a particular physician to guide his treatment from sickness back to health or will he look to a hospital?

The hue, cry and concern about the corporate practice of medicine is not a new battle cry. Resolutions of the American Medical Association House of Delegates have deplored the corporate practice of medicine in the United States practically since the founding of the AMA. The present ramifications of corporate practice of medicine, however, are different and more sophisticated than ever before.

In the past, laymen seeking personal financial gain endeavored to hire physicians, exploit them and sell their services at a profit. Some proprietary hospitals operated for profit similarly hired

The author is a member of the Office of General Counsel of the American Medical Association. She presented this paper at the North Central Medical Conference October 20, 1973 in Bloomington, Minnesota. physicians on a salary basis, sold their services and profited while perhaps providing poor services because only incompetent or inept physicians were tempted by the salary offers. Today, the threat of corporate practice involves many of the finest hospitals and teaching institutions in the United States; well-funded community hospitals and teaching hospitals allied to prestigious universities and medical schools. Consequently, the threat of the corporate practice of medicine to the interests of the patient and the physician is more real and more insidious than ever before.

When a university affiliated teaching hospital becomes more interested in treating individuals as teaching material than in treating them as patients, when research is given higher priority than success in treating individual patients, when staff physicians are subjected to constant pressure to publish journal articles and obtain research grants, individualized patient care yields and the corporate spector—the image of the corporate giant versus the individual physician—becomes a matter of deep concern for practicing physicians. Teaching and research have their proper place, but the physician-patient relationship should be dominant. The corporate practice of medicine, or perhaps more correctly, the trend of hospitals to engage in the corporate treatment of patients is now spreading to non-teaching hospitals and is reported with increasing frequency in hospitals operated by religious organizations.

#### PATIENT CARE

If the medical care of patients is to remain the primary responsibility of physicians and not impersonal corporations, then it is mandatory that the organized medical staff of a hospital truly function as the name implies with emphasis on the word "organized." The hospital medical staff is and should be more than a group of individual physicians who have some sort of relationship to

the hospital and its governing board by virtue of the hospital privileges accorded them individually.

The individual medical staff physician has an obligation to the organized medical staff; the obligation to participate productively and responsibly. Likewise, the organized medical staff has a basic obligation to discipline its members so that together they may fulfill through self-government and self-direction the medical management of the hospital. If the medical staff defaults in this obligation, the governing board can be expected to react. When laymen alone attempt to make decisions which should only be made upon the recommendation of physicians, patient care can be expected to suffer and the concept of professionalism to deteriorate.

To provide for the best interests of patients and the physicians who serve patients, the governance of the hospital should function as a partnership between the governing board carrying out its responsibility for the business management, operation and administration on the one hand and the organized medical staff carrying out its responsibility for the medical management of the hospital on the other hand.

The governing board of the hospital is entitled to an organized medical staff that governs the medical affairs of the hospital efficiently, economically, and in the best interests of the patients, the physicians and the institution. The medical staff should be well organized and exercise its self-governing prerogatives diligently and responsibly.

#### PHYSICIANS ON BOARDS

The governing board of a hospital is a lay board. It is a lay board even though some of its members may be physicians. Whether the governing board of the hospital is composed entirely of laymen or includes some or all physicians, neither the hospital nor the governing board as such is licensed to practice medicine. Only physicians are authorized legally to practice medicine. This brings us to the question of whether it is desirable, important or necessary for the governing board of a hospital to have physicians as members. There have been instances where governing boards have engaged in the practice of making medical decisions reflecting the views of physician board members.

A physician on the hospital governing board is there to act in a management capacity and not to make medical decisions. Some medical organizations, including the AMA, have advocated having at least one physician on the hospital governing board. This can work well if the purpose is to have a conduit for communication between the governing board and the medical staff. It can work well if the physicians so included are not engaged in making decisions that should emanate from the organized medical staff itself.

The physician member of a hospital governing board who does not serve as a conduit of communication and who does not sit as a representative of the medical staff often is responsible for engendering disputes between the governing board and the medical staff. This can occur if the governing board relies more on the physician member for medical input than on the organized medical staff. What is important is not whether a physician is on the governing board but whether two-way communication between the governing board and the medical staff is currently and intelligently maintained.

Ideally, a hospital's primary objective—that of providing high quality patient care services for the community—can be achieved best if there is a close working relationship and effective cooperation between the two groups who share the responsibility for hospital operation: (1) the board of directors or trustees responsible for the business management, housekeeping and prudent use of the institution's resources to attain quality patient care; and (2) an organized staff of physicians practicing within the hospital and responsible for the methodology and implementation of the system under which the resources of the medical community are used to provide the best attainable quality of medical care and services.

In some hospitals, the governing board apparently suffers from the misconception that it is responsible for making medical decisions and exercising medical discretion in assuring high quality patient care. The governing board is a lay instrumentality of hospital management. The board is responsible to the community, to charitable donors, to governmental agencies that provide funds, but first and foremost to patients. The board is responsible for seeing to it that funds are spent wisely to bring together the best available facilities and services that budgetary considerations can provide for quality patient care.

The governing board's responsibility includes permitting only qualified, competent practitioners to use the hospital facilities. With respect to physicians, a lay board frequently can make negative judgments as to ethical, moral and medical competence to practice. For example, laymen are capable of determining that physicians with criminal records or those excluded from other hospitals because of medical malpractice or lack of reasonable cooperation with the nursing staff and the hospital administrator should not be permitted to practice in the hospital. With respect to medical evaluations, the fact-finding of medical competence or incompetence must be left to the physician's peers who have observed his performance and evaluated his ethical and professional credentials.

#### RESPONSIBILITY

It has often been said that the governing board of the hospital is legally and morally responsible for the quality of patient care within the institution. Unfortunately, these words have been misinterpreted—sometimes innocently and sometimes deliberately—with respect to physicians' services. In the case of salaried physicians, responsibility may mean that the hospital is liable in damages for their malpractice. Even with salaried physicians, however, the courts are divided as to whether the hospital is or is not liable for their professional services.

In some of the states where hospitals have been held legally responsible for the negligence of salaried physicians, the courts have treated physicians serving as independent contractors when providing medical services in the hospital as if they were employees in cases where the hospital furnishes the services of the physician and the patient has no voice in his selection. Included in the category of physicians who are independent contractors for purposes of providing professional services in the hospital but employees for purposes of patient liability are anesthesiologists, pathologists, radiologists and physicians serving in the emergency department.

There is not one single reported case in which a hospital has been held legally responsible for the malpractice of an attending, competent physician engaged in independent practice and selected by the patient.

#### DARLING CASE

Some hospital consultants, hospital administrators and their attorneys have spread an erroneous interpretation of the *Darling* case with such frequency that there seems to be a generally held opinion that the misinterpretation accurately reflects the law of the land. Nothing could be fur-

ther from the truth. In the nine years since the *Darling* case was first tried, it has either been entirely rejected by other courts or narrowly construed.

Darling is an Illinois case and even in Illinois the case has been given a narrow construction. Some of those hospital administrators, governing boards and their attorneys who cite Darling as a precedent would have physicians believe that the hospital is jointly responsible for any act of malpractice they may commit in the delivery of medical services within the hospital. With this as a base, they say that if the hospital is responsible for the attending physician's mistakes, it has the right to supervise and direct his services. This is not what the Darling case holds.

Before a hospital can be held liable for the mistakes or negligence of an independent, attending physician, there must be some showing of negligence on the part of the hospital. The hospital must be proven negligent in its own right. Hospital negligence can be found, for example, if a physician of known incompetence is permitted to continue practicing in the hospital or is granted privileges.

In the *Darling* case, the facts are basically simple. The services of the physician as described in the case clearly show negligence. Although the physician involved was not an employee of the hospital and was engaged in the independent practice of medicine, nevertheless, the services from which the negligence arose took place when he was on emergency call.

Darling, who received negligent care in the setting and followup treatment of a broken leg, did not select the physician. The physician was on emergency call and provided by the hospital. Insofar as the medical care delivered, a physician selected and provided by the hospital has status similar to one who is on a salary basis.

In essence, the court held the hospital responsible for the physician's negligent treatment; first, because his services were provided by the hospital, and secondly, because the facts of the case show and the court found that the nursing care was negligent. The nurses failed to call attention to what was obviously a gangrenous condition as evidenced by the continuing excruciating pain of the patient and the foul and putrid odor that filled the room.

The reported cases in the various states fol-

(Please turn to page 55)

#### HOSPITAL-STAFF RELATIONSHIPS

(Continued)

lowing *Darling* either have rejected the case as a precedent or have followed it as precedent for hospital liability for employee negligence.

The developing trend on the part of some hospital governing boards to attempt to exercise direction and supervision over staff physicians in reliance on the *Darling* case is widespread enough to be of grave concern. In some of these hospitals, such control is exercised by the governing board's appointing salaried department heads, salaried chiefs of staff and a medical staff executive committee of salaried physicians. The members of the attending staff then become subject to the direction of the salaried physicians. Under these circumstances, the medical staff is not self-governing and has no separate existence as a deliberate medical body.

#### DIVIDED LOYALTIES

When the chain of command and control stems from a lay governing board, there are influences which conflict with the physician's undivided loyalty to his patient. Salaried physicians in a line of command to the governing board have divided loyalties between the interests of the institution and those of the patient which ideally should not be in conflict.

In some institutions, the situation has become so grave as to create a line of authority that goes from the attending staff to a salaried medical heirarchy which in turn is responsible to a hospital administrator—often styled as president of the hospital and frequently not only the chief hospital executive but the dominant voice on the hospital governing board. In institutions where the hospital administrator occupies the role of hospital president and chairman of the hospital governing board, the only line of communication between the governing board and the medical staff is through him. This is lay domination at its zenith and a trend that should be aborted as early as possible.

It is too late in time and not practical to turn back the clock and engage in a campaign against the salaried employment of physicians in hospitals. Quality care requires that the employment of salaried physicians in hospitals should be subject to the condition that the salaried physicians must obtain and continue their hospital privileges in the same manner as other attending physicians; that is, upon the recommendations of the organized medical staff following evaluation of their credentials. In the absence of any clear showing that the organized medical staff has abused its functions, its recommendations should be accepted by the governing board.

Physicians function best when they are self-governing, when they accept the supervision and direction of their peers' evaluations and are selected through democratic processes. Attending physicians who are salaried and depend only upon a lay governing board for their authority do not normally receive the respect of other physicians. Their position is given to them by laymen and not earned through medical achievement and recognition.

Unfortunately, medical democracy can only be achieved where the governing board is enlightened and follows the procedures recommended by the Joint Commission on Accreditation of Hospitals. The courts are not available under existing laws and judicial precedents to guarantee a medical staff self-governance and self-determination in medical affairs. No court has held a not-for-profit hospital to be engaged in the illegal practice of medicine although in a few jurisdictions, such as Iowa, there are statutes that prohibit the corporate practice of medicine by hospitals.

#### **ASSURING RIGHTS**

How can physicians protect their professional rights and assure self-governance in medical matters in the hospital setting? It does not seem likely that any court would rule that salaried physicians within the hospital must be cleared by the medical staff and continue as members of the medical staff. How can individual attending physicians protect themselves from dominance by full-time salaried chiefs of staffs? How can medical staffs assure themselves a direct line of communication to the governing board? What weapons are available to a medical staff in dealing with a recalcitrant or misguided governing board?

Although physicians engaged in the independent practice of medicine are largely entrepreneurs with respect to their financial arrangements with patients, nevertheless such physicians have

a great deal in common with salaried physicians when they treat patients in a hospital.

It is abundantly clear that the hospital privileges given to a particular physician should be quite explicit with respect to what he can and cannot do in the treatment of patients within the hospital. As a practical matter, the professional man performing services for a patient in a hospital is governed by rules that differ little from those of a salaried physician treating patients, for example, in a university affiliated hospital where all physicians might be on a salary basis.

The attending physician is given to understand what he can and cannot do in the treatment of patients. There are rules he must observe as to when he must obtain consultation. To a large extent he must follow a medical methodology and order tests as required by the hospital rules. Like employees in an employer-employee relationship, his work is or should be under the constant surveillance and scrutiny of his peers in the framework of the organized medical staff.

In common with the employee, the so-called independent, attending physician is required to attend medical staff meetings; he is assigned committee chores; and he may be assigned involuntarily to take his turn on call in the emergency department. As is required by those who have an employee relationship with the hospital, the attending physician's hospital privileges require him to observe the administrative rules and procedures of the hospital which the governing board or the hospital administrator may establish for the orderly operation of the hospital.

The physician who loses his hospital privileges for cause has a great deal in common with the salaried physician who is fired for cause. It is a truism that the physician's hospital privileges make him just as economically dependent on the hospital as an employee is on his employer.

#### COMMON CHARACTERISTICS

If it is true that attending and salaried physicians have numerous characteristics common to their occupational performances, it is likewise true, even though some physicians may prefer not to engage in such comparisons, that the hospital and its governing board have a relationship to the attending physician quite comparable in nature and responsibility to the governing board's relationship to employees in the hospital.

The governing board is obligated to be selective in granting hospital privileges to qualified physicians. In executing this function, it should rely on the evaluation of professional attainments made by the organized medical staff. Without belaboring the point, it is quite obvious that the hospital, either directly through the administrative processes of the governing board or through the operation of the organized medical staff functioning on behalf of the hospital, exercises a great deal of control over the attending physician; control that matches the control employers exercise over employees.

Furthermore, just as there is close economic mutual dependence between employers and employees, there is perhaps an even closer mutual dependence between the hospital and the attending physician who is responsible for bringing patients to the hospital.

Identifying the common characteristics of attending, independent physicians and employees has great legal significance. Employees have strong, legally protected, economic weapons which they are entitled to use in "labor disputes" with their employers over terms and conditions of their employment. The Clayton and Norris-LaGuardia Acts specifically exempt "labor disputes" from the application of the Sherman Antitrust Act.

The term "labor dispute" is not limited exclusively to those persons who are wage earners. In the case in which the AMA was held to be in violation of the Sherman Antitrust Act, the United States Court of Appeals by way of an aside pointed out that there were circumstances under which physicians who were entrepreneurs could qualify for the same protection afforded wage earners engaged in labor disputes. In other words, where the issue involves the terms and conditions under which labor is expended, whether by wage earners or independent contractors, the exclusion from the antitrust laws should be applicable.

In general, the federal antitrust laws prohibit unreasonable restraints against interstate commerce. Hospitals have been held to be engaged in interstate commerce and therefore subject to the antitrust laws and entitled to the protection of the exceptions to those laws.

In a dispute between a hospital governing board and the organized medical staff, what are the limitations upon what the medical staff can do to enforce its demands concerning the terms and conditions under which attending physicians serve patients in the hospital? What can the medical staff do to protect itself against a governing board that wants to make physicians the servants of the hospital rather than the patient? What can the medical staff do to protect medical professionalism from conversion to the institutionalized practice of the healing arts? What can be done to prevent the hospital-patient relationship from becoming dominant over the physician-patient relationship?

#### REASONABLE MEASURES

The antitrust laws prohibit unreasonable restraints. Reasonable restraints are not prohibited. At a minimum, the organized medical staff can use reasonable measures to improve the terms and conditions under which its members exercise hospital privileges and undertake countermeasures to the actions of the governing board. Reasonable in such cases would be determined in light of the action taken by the governing board.

Although the issue has not been litigated, in particular situations it appears that the organized medical staff should be entitled to the kind of economic and other weapons that trade unions, which are exempt from the antitrust laws when engaged in labor disputes, use in dealing with employers.

At stake in all of this is the physician's professionalism—the right to give top priority to the individual physician-patient relationship. Institutional objectives such as the provision of patient care that meets high statistical standards, sometimes is achieved only at the expense of the individual patient.

There is an important role for the medical society in all of this. If the medical staff is to function as a collective unit on behalf of its members, it must have the assistance and guidance of those who are professionals in the process of arbitration, mediation and collective negotiation. No matter how highly trained as practitioners, physicians are novices and not professionals in the art of negotiation and mediation.

Hospitals have governing boards of businessmen, trained administrators and highly qualified attorneys, sometimes even professional labor lawyers, who guide the hospital's dealings with the medical staff. Often this professional team of ad-

ministrators and lawyers is not visible, but their guidance is always present.

In physician-hospital disputes, the medical staff must have a comparable team of experts if medical practice is not to be institutionalized. This should be the role of organized medicine with the county medical society at the firing line providing direction and guidance to equalize the bargaining position of the medical staff.

Just as the union provides a business agent and legal experts to represent employees in difficult dealings with their employers, the same kind of help should emanate from county and state medical societies with AMA participation.

It is no longer sinful or despicable for medical societies to be called physician unions. The National Education Association, for example, an old-line professional association of teachers, learned this the hard way after the AFL-CIO got into the picture. Now the NEA openly and aggressively functions as a union. If organized medicine is unwilling or unable to accept the challenge, then most assuredly the physician union movement will flourish and fill the vacuum. Unfortunately, they cannot do the jobs as well as organized medicine.

#### LEGITIMATE GRIEVANCES

Physician-hospital disputes are not necessarily one-sided affairs. There may be instances where there are legitimate grievances on one side or the other or mutual grievances of a legitimate nature. A few instances have come to the attention of the AMA where the organized medical staff has been lax in instituting recommended reforms or in keeping bylaws current. The result has been that harsh consultants were called in by the hospital swinging the pendulum too far in the opposite direction.

A medical society that has objective, qualified professionals to help it can render the best service by objectively pointing out where and how remedial measures should be voluntarily undertaken. Responsible unions do this also when members fall out of line and the employer calls upon the union to help correct the situation.

Medical societies can help by preparing materials such as kits of educational materials. A do-it-yourself handbook is insufficient, however, to deal with a governing board that is represented by high priced lawyers and professionally trained administrators.



# The Question Box

by RALPH L. WICKS, M.D.

Ralph L. Wicks, M.D., Iowa Medical Society president-elect, has been a successful physician recruiter in Boone. He relates a little of his thinking on the subject in the following.

# What is your basic philosophy about physician recruitment?

My philosophy derives largely from my first association or partnership which proved very unsatisfactory. I found I was doing more than 65% of the work of the partnership while receiving less than 50% of the income after all office expense was paid. This was in accord with a contract to which I agreed, but I decided never again would I be on either side of such an agreement.

#### What about your current status?

A subsequent arrangement with another practitioner proved entirely satisfactory and continues to exist 25 years later. Now there are four physicians and one physician's assistant; a fifth physician is expected in the near future.

#### What about today's young physician?

It is my belief the younger physicians today are receiving excellent training and are dedicated to their profession. In these changing times, when people are requiring and deserve better and better care, it becomes more and more important to practice in associations or groups. At no time in our contacts and negotiations have we considered substituting quantity for quality.

#### Do you have good rapport in your group?

Each man in our group participates in forthright discussions and is receptive to honest criticism. In my opinion, it is not possible for an association to work where one profits from another man's endeavors. And it is my feeling that age and experience at least partially offset the superior knowledge and education the young people are receiving today.

# What financial arrangements do you provide in your present group?

We have a strong belief in "fee for service." A physician's service is to his patient, not to his senior partner. We have a simple arrangement where each of the partners receives a share of the after-expenses income on the prorated basis of the amount of income which his work produces.

# When does a newcomer achieve partnership status?

We agree upon a salary arrangement for a period of from six to 18 months. This trial period is mutually beneficial. It ends when the newcomer is producing enough income to assure himself he is carrying his part of the total partnership. The partnership does not involve a 50-50 or any definite percentage arrangement, but is based strictly upon the individual's production, i.e., he takes out of the partnership exactly the percentage he is producing. This is estimated at the beginning of each year and corrections are made at quarterly or other appropriate intervals.

#### How does this approach affect you?

Our accountant said to me after three younger physicians had become partners, "Why is it that you, the senior partner, are getting a lower percentage than others of the group?" My reply was, "I am not working as many hours as they are and I have no desire to profit from their efforts." I feel I have been and am continuing to be paid for what I am doing and I feel more comfortable in setting my own pace.

(Please turn to page 73)



# Patient Care Evaluation in an Iowa Hospital

JOHN MURPHY, M.D.
CHARLES LINDEN, M.A., and
RICHARD CAPLAN, M.D.

Boone and Iowa City

Patient-care evaluation, peer review and continuing medical education can be a simple, natural process for the practitioner in the small to medium-sized private hospital. The staff of the Boone County Community Hospital has successfully welded these three functions into a practical scheme characterized by hospital staff cooperation and results. And this has been accomplished in reasonable harmony with busy private practices. This paper will describe our approach, in the hope other groups may benefit from our activities and solutions.

The Boone medical community includes a 160 bed general, medical-surgical hospital staffed by 12 family practitioners, a general surgeon and three radiologists. Visiting consultants provide services in pathology, urology, orthopedics, internal medicine, obstetrics and gynecology and ophthalmology. The medical community serves a

community of 13,000 people and a similar number in the surrounding rural area.

Four years ago the responsibility of evaluating patient care was divided between a tissue and record committee and a utilization committee. The former committee reviewed charts pulled at random, single-unit transfusions, reports of surgical specimens, and deaths. The utilization committee reviewed 14-day acute hospital stays and 28-day extended care hospitalizations. Committee reports focused on conclusions and recommenda-

A revamped plan for evaluating patient care has been implemented by the physicians in Boone County. The results have been uniformly good. Medical performance is now looked at objectively, rationally and non-threateningly.

tions about chart completeness, plus an occasional suggestion that a patient could be transferred to a nursing home. The work was dull and seemed pointless. It was difficult to see how either patient or physician benefited from such drudgery.

We felt patient-care evaluation and utilization review to be inseparable. Therefore, with a little persuasion, the medical staff agreed to reorganize the two committees into one unit. The goal has been to improve the level of care provided to our patient through two methods: first, by scrutiny of our past performance measured against what we considered optimal levels of care, and second, by

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF FEBRUARY, 1974.

Dr. Murphy is in the private practice of family medicine in Boone. Mr. Linden is administrator of the Boone County Community Hospital. Dr. Caplan is Assistant Dean, Continuing Medical Education, University of Iowa College of Medicine.

identification and management of current problems including utilization of facilities. Happily, the elements of peer review and physician education were unavoidable bonuses. We began to review patient care by subject, e.g., primary Caesarian section, with pre-established criteria of optimal care. Soon we found ourselves drawing conclusions regarding the effectiveness of the job we were doing. Recommendations for change subsequently evolved from the committee activities and involved physician education, hospital-staff policy change, and remarkably, peer review.

The new committee is called the Medical Care Evaluation Committee. In our situation seven members seems the most propitious size. This amounts to about half of our active hospital staff. There is a general chairman with an assistant chairman for a subject-review section and an assistant chairman for utilization. These positions of assistant chairmen are rotated among the six "working" members of the committee so that each member serves as an assistant chairman of each section for two months a year. This mechanism has provided a continuous series of new ideas and enthusiastic chiefs. Those who have served on committees will recognize the importance of establishing this rotating responsibility to get the job done.

#### INITIAL AGREEMENTS

Several agreements were reached at the outset: 1) an understanding that controversial subjects would not be avoided; 2) that the goal of medical education should override the privileges of anonymity where physician-problems were discovered; 3) that outside medical authority and advice would be sought freely; 4) that the committee would operate by majority rule; and 5) that conclusions and recommendations would evolve from the studies for the purpose of improving patient care in our hospital. There have been some lively, even hot, discussions and no one sleeps in staff meetings anymore. But more importantly, from all this have come changes in methods which we believe are for the better. Moreover, the drudgery of the old tissue and record committee has been replaced by a reasonable and stimulating system of self-appraisal that produces identifiable improvement in patient care.

The new committee began its auditing work with no previous experience. Initially, we picked medical topics where we felt problems existed, quickly established our criteria, did much of the chart research ourselves, and then looked at our data to learn what was really happening in our hospital. Through a great deal of trial and error and the addition of several references of patientcare review we have added sophistication to our endeavors. Topics reviewed have included such diverse matters as surgical management of fractured hips, primary Caesarian section, high risk pregnancies, a long term study of neonatal stresses and their ultimate effect on learning and school performance, anemias, diabetes, eye injuries, use of narcotics in our outpatient department, bacteriologic specimen collection, prostatic surgery, breast biopsies, IPPB contamination and chronic lung disease, management of uterine leiomyomata, chart legibility, fetal resuscitation, hyperbilirubinemia, cholecystitis and cholelithiasis, T & A's, hemorrhoids, and anesthetic technique.

Admittedly, these studies have not been subjected to rigorous statistical testing, but in every case there has been an honest effort at self appraisal. The studies do identify problems and trends of care. And they have been performed entirely by busy practitioners in private practice. The kind of medical audit we perform involves the developing of a group of pre-established criteria of care, and then checking actual medical records to see how close our actual performance came to matching our pre-established standard for that criterion. This type of audit involves physicians in the professional role of deciding together what good care means, and how to go about improving any discovered deficiencies-instead of pawing through a pile of charts with no defined method for evaluation. In that old way, we felt we learned nothing, accomplished nothing, wasted time and effort, and felt the need to take more antacids.

#### FIVE IMPORTANT FACTORS

Several things have been learned that may help others about to start a similar program. These fall into five areas: first, guidelines and criteria of care already available; second, methods of data retrieval and efficient use of paramedical personnel; third, better ways to record clinical information on patient records; fourth, the drawbacks of "too much" of this efficiency; and fifth, what you can expect to accomplish.

First, guidelines and criteria of care already available: The following is a short list of references we used to help choose criteria of optimal care. Ahead of any of them should be listed trial

and error. Otherwise, the list is arranged in the order that served us most usefully.

- 1. Hospital Utilization Review Manual, Beverly C. Payne, M.D., Editor, University of Michigan, Ann Arbor, 1968
- 2. Iowa Foundation for Medical Care—Iowa Standards of Care, published by Iowa Foundation for Medical Care, Des Moines, 1972
  - 3. JCAH-TAP Institute Materials
- 4. CPHA-PAS Data and Reference Material, Commission on Professional and Hospital Activities, Ann Arbor

This material was particularly helpful as a time saver in the beginning; now we find it more useful and interesting to develop our own criteria. It is essential, however, that the local group consider each "imported" criterion thoughtfully before adopting it as its own standard. Care must be taken, also, to seek areas of review that are suspected problems in your own hospital and not merely perform easy-to-do cookbook studies. We are not interested in aimless academic exercises.

Second, methods of data retrieval: Medical record administrators can seek the desired information by reading the appropriate charts. Although a time-consuming process, it permits chart reading to be done by non-physicians almost entirely. With some guidance, the medical record administrator, the hospital administrator, nursing service, and occasionally other paramedical personnel can do about 90% of the actual data retrieval. Hospitals will likely increase their use of computerized hospital abstracts, such as are available from PAS (Commission on Professional and Hospital Activities, Ann Arbor, Michigan) or the Health Services Data System of the Iowa Hospital Association. We have learned that a properly stated narrative summary will contain almost all the review data needed. We therefore suggest that paramount emphasis be placed on the preparation of good summaries as follows:

- 1. Dates of Admission and Discharge
- 2. Final Diagnosis
- 3. Operative Procedures
- 4. Pertinent Points of History
- 5. Pertinent Points of Physical Examination
- 6. Results of Laboratory and X-Ray Studies
- 7. Hospital Course
- 8. Condition on Discharge
- 9. Follow up and Disposition (including discharge medications)

Third, better ways to record clinical information on patient records: We believe that the problem-oriented record will ultimately offer an improved path through the morass of clinical data that now reaches the medical record room. Some of the medical staff are already using this system in their offices and in time we hope to employ this approach uniformly in our hospital. Perhaps of more immediate value, we have reached mutual agreement about the inclusion of pertinent positive and negative medical information in clinical records. We have also discovered our nursing notes to be a source of useful information as well as occasional consternation and amusement.

Fourth, the drawbacks of "too much" of this efficiency: Our review of need for admission, length of stay and timeliness of dismissal coupled with the development of suitable nursing home beds locally have lowered our admission rate and our average length of stay. This has created some hardship on the fiscal health of the hospital through a declining census. This dilemma is enviable on the one hand and distressing on the other. The kind of adaptive response to be made eventually by the hospital is not yet clear.

Some of the problems encountered include implementing a program of staff education related to both the quality-of-care review program and the needs of the staff, and in some instances, dealing with deficiencies of individual physicians. This can generally be accomplished by the committee's reporting to the staff on standards of care, and inadequacies demonstrated.

#### OPEN DISCUSSION

We have found when the Medical Care Evaluation Committee presents its reports and recommendations at general staff meetings, the ensuing discussion usually reveals general agreement on the recommendations. The staff members accept the concept that these recommendations are for the improvement of patient care and therefore is of help to them in their practice of medicine. If an individual physician regularly deviates from the generally accepted standards, it may become necessary to deal with the physician individually. If this is not effective, the appropriate staff committee will have to deal with the problem when re-appointment and staff privileges are considered. However, honest differences of opinion along with proper discussion will in most situations result in an amicable solution, plus educational benefits for all involved.

Finally, what you can expect to accomplish: We have learned to accept our new system with considerable enthusiasm. So can you. We have en-

joyed a great deal more openness in our discussions of problems related to patient care. So will you. We have drawn conclusions on the basis of our studies and implemented policy changes that have altered patient-care patterns for the better, and we can prove these things. So will you. Moreover, we have developed a way of looking at our own medical performance objectively, rationally, and non-theateningly with a means to make changes where they were needed. So will you.

We have evolved a format for locally-based continuing education which captures our interest and provides us a real sense of professional growth while making the practice of medicine more satisfying. So can you. And finally, we feel ourselves well prepared for coping effectively and non-neurotically with the PSRO concept and whatever its operating rules may prove to be, since they will be based on the concept of audit for patient care evaluation. And so can you.

# QUALITY ASSESSMENT CONSULTATION PROGRAM

The Office of Continuing Medical Education at the University of Iowa College of Medicine has initiated a new service for health care institutions. The program is offered in cooperation with the Iowa Foundation for Medical Care and the Iowa Hospital Association, and is supported by the Iowa Regional Medical Program.

Intended for hospital medical and administrative staffs as they implement programs to assess the quality of care, the service will offer assistance at no cost on the following basis:

- 1) Personal questions will be answered by telephone (319/353-5763) or by letter (101 CMAB, Iowa City, Iowa 52242).
- 2) Selected references and article reprints will be provided on request.

- 3) Quality assessment studies provided by Iowa hospitals will be received and compiled into a specialized library. These studies will be rendered anonymous and will be made available to other institutions, as appropriate, to speed and ease the task of conducting similar studies in a different setting.
- 4) On-site consultation will be available on request to a person (generally a physician) experienced in conducting such studies. A limited number of such visitations will be available, not for giving a talk, but for working in concentrated fashion with a committee that has already made an effort to learn, but needs help in implementation, or interpretation, or planning educational responses found to be needd.

Funding of this service is assured only until July 1, 1974, thus contact is urged as soon as possible. Richard M. Caplan, M.D., Assistant Dean, Office of Continuing Medical Education, will welcome inquiries.

# Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

1974 Feb. 2

Ophthalmology Clinical Conference

Community Clinical Conference (Estherville)

Refresher Course for the Family Physician

Mar. 1

**Ophthalmology Clinical Conference** 

Mar. 6

Diet Therapy U.S.A.

Mar. 16-17

Conference on Human Sexuality—Medical Aspects

Mar. 25-28

Cardiology Today

Feb. 9-10 Feb. 12-15

# Cancer in Iowa-1970

# A Preliminary Report on Frequencies and Trends

JOHN W. BERG, M.D. lowa City

Findings of 1969-1970 survey show one cancer for every 4.4 lowans. 11% drop has been noted among women, with a 12% increase among men. New Cancer Epidemiology Research Center will assist in data-finding and control programs.

BECAUSE CANCERS are primarily environmental diseases, their incidence varies both geographically and with time. The Third National Cancer Survey, in which Iowa was a major participant, was designed primarily to obtain up-to-date information on incidence from representative parts of this country. While the final data will not be available for several months, enough is now on hand to see how things have changed in Iowa since 1950 when the last survey was done and to determine what are our most pressing current problems.

The data presented here are generally valid but are preliminary data in several senses. They do not include 1971 cases. They have not been subjected to the ultimate cross checking projected for the Third National Survey data. They have not been arranged in their final groupings nor re-arranged for optimal comparisons with the 1950 survey data. Skin cancers are not included since they are such difficult cancers on which to obtain complete counts. Rather, a special study

of them was undertaken which will be analyzed separately. In situ cervical cancers also must be treated separately since their apparent incidence is dependent first of all on the extent of screening and they were not being searched for in 1950.

Excluding skin and in situ cervical cancers, 18,-269 cancers were registered by the Survey in 1969-1970 (Table I). These represent one cancer for every 155 Iowa residents during the two

TABLE I

NUMBERS OF NEW CANCERS REPORTED IN IOWA

RESIDENTS

1969-1970

Site	lumber of Ca	ses
Large bowel	3,051	
Breast	2,466	
Lung	2,069	
Prostate	1,653	
Leukemia and myeloma	930	
Bladder	828	
Uterus except cervix	710	
Lymphomas	648	
Mouth and pharynx	633	
Stomach	613	
Pancreas	540	
Cervix, invasive	501	
Ovary	480	
Kidney except pelvis	338	
Central nervous system	275	
Larynx	224	
Gall bladder and bile ducts	202	
Melanoma	169	
Thyroid	159	
Esophagus	151	
Soft tissues except retroperitoneal	122	
Testis		
Other specified sites	775	
Unknown primary site	632	
Subtotal	18,269	
In situ cervical carcinoma	833	
Total (basal-cell and squamous-cell skin carcino	mas	
excluded)	19,102	

Dr. Berg is Director, Cancer Epidemiology Research Center, Department of Preventive Medicine and Public Health, University of Iowa College of Medicine. This material has been prepared by Dr. Berg with the Iowa and National staffs of the Third National Cancer Surveys, which include E. E. Mason, M.D., and J. A. Buckwalter, M.D., Directors, Iowa Field Office; Mrs. Mary Nance, Supervisor, Iowa State Cancer Registry; Sidney Cutler, M.D., and John Bailar, III, M.D., Directors, Third National Cancer Survey; Mr. Harvey Geller, Head, Special Cancer Survey Section; and Mrs. Constance Percy, liaison.

years or an average annual crude incidence rate of 323.5 per 100,000 population. Summing this rate over a life expectancy of 70 years would mean one cancer for every 4.4 individuals. The figure may be closer to 1 in 5 Iowans as a cancer victim because some will have more than a single cancer during their lifetime.

As Table I shows, bowel cancer was the most common major cancer among Iowans although men developed more lung cancer and prostatic cancer while women developed more breast cancer. Men developed more cancers than did women. Among major types of cancer found in both sexes only bowel cancer and gall bladder cancer were more common in women. However, men would have had much less cancer than women did they not smoke; the cigarette linked

cancers of the lungs, larynx, mouth, pharynx, esophagus, pancreas, kidney, and bladder made up 37% of all cancers in men. If all Iowa men had the cancer rates of non-smokers, we estimate that they would have been spared more than 2,700 of these cancers, 29% of the total.

The first comment to be made about time trends is that Iowa is becoming a little more like the rest of the survey areas. In 1950 Iowa's cancer rate was 90% of that of other survey areas; now it is 93%. When one looks at changes in rates within the state, cancer in women has dropped 11%, but cancer in men has risen 12% (Table II). The increases for men are primarily in the cigarette associated cancers: lung cancer rates have tripled, laryngeal cancer rates have risen even more, and there have been important in-

TABLE II

COMPARISON OF CURRENT IOWA INCIDENCE RATES†

WITH 1950 RATES (AGE STANDARDIZED TO 1950 U. S. POPULATION)

		Men			Women	
Site	1950	1969-70	% Change	1950	1969-70	% Change
Lip	16.4	5.9	- 64	1.0	0.2	- 80
Tongue	1.4	2.0	+ 43	0.7	1.0	+ 43
Salivary glands	2.4	1.0	<b>- 58</b>	2.2	1.0	- 55
Other mouth	4.8	2.9	- 60	1.2	1.1	- 8
Pharynx	2.8	3.5	+ 25	0.5	1.0	+100
Esophagus	3.0	3.8	+ 13	0.9	0.7	- 22
Stomach	24.7	10.8	<b>- 56</b>	13.6	4.8	- 65
Small intestine	1.3	1.6	+ 23	0.7	0.9	+ 29
Colon	21.0	28.1	+ 34	25.9	28.1	+ 8
Rectum	14.2	15.2	+ 7	10.5	9.9	- 6
Liver	3.5	1.7	– 51	4.3	0.8	- 8I
Gallbladder and bile ducts	1.6	2.2	+ 38	3.9	2.7	- 31
Pancreas	6.9	8.9	+ 29	5.1	5.3	+ 4
Larynx	2.1	6.8	<b>+224</b>	0.5	0.6	+ 20
Lung	18.8	56.2	+I <b>99</b>	6.6	9.0	+ 36
Breast	1.0	0.5	<b>– 50</b>	70.3	70.5	+ 0.3
Cervix in situ	_	_	_	_	35.5	_
Invasive	_	_	_	33.4	17.6	<b>– 47</b>
Other uterus	_		_	22.7	20.8	- 8
Ovary	_	_	_	13.6	14.2	+ 4
Prostate	35.8	44.9	+ 25	_	_	_
Kidney	4.1	6.6	+ 61	3.0	3.4	+ 13
Bladder	16.2	18.7	+ <b>15</b>	5.0	4.3	- 14
Central nervous system	6.0	5.I	— 15	3.2	4.3	+ 34
Thyroid	1.4	1.5	+ 7	2.6	3.9	+ 50
Bone	2.5	0.9	– 64	1.6	0.7	<b>– 56</b>
Soft tissue	2.2	2.0	- 9	1.8	1.7	- 6
Lymphomas	9.0	11.8	+ 31	6.3	8.1	+ 29
Leukemia and myeloma	12,7	15.6	+ 23	9.0	9.7	+ 8
Other specified sites	8.4*	10.9*	_	8.0*	6.9*	_
Unknown site	10.8	9.7	<b>– 10</b>	13.3	7.2	_ 46
Total excluding skin and in situ cervix cancers	235.0	279.5	+ 12	271.4	242.4	<del>- 11</del>

<sup>\*</sup> Not directly comparable, included for sake of completeness.

<sup>†</sup> Per 100,000 population.

creases in pancreatic, kidney and bladder cancer. Colonic cancer, prostatic cancer, lymphomas and leukemias also have increased in men while lung cancer, thyroid cancer and lymphomas represented the important increases for women.

The most important decreases in cancer incidence are those of stomach cancer and invasive cervical cancer. The change in stomach cancer is part of an unexplained continuing national trend. Total cervical cancer is not decreased, but many of us consider the in situ variety really only a precancerous dysplasia. Certainly it implies very little later mortality so that whatever the theory, in practice we have a diminishing disease.

We presume the apparent decreases in lip cancer, salivary gland cancer, liver cancer, and bone cancer are at least partly artifacts resulting from more precise designations of primary site and type in the later Survey. The earlier excess lip and salivary gland cancers probably represent tumor types not recorded in the present survey while some of the excess liver and bone cancers represented metastatic cancers more properly coded to unknown primary site.

For most cancer sites Iowa reported lower rates than the average of all areas in the Survey. Only cancers of the small intestine and leukemias were more common in Iowa than in any other area. The leukemia problem is a longstanding one af-

fecting a north-central U.S. belt from Michigan through Kansas and Nebraska and deserves much more study. Other research opportunities are expected to become visible when the full survey data are on hand and when urban-rural comparisons are made. While we look for special situations that can teach us about causes or control, the general priorities already are clear. The single greatest problem is prevention of the cigarette cancers. The second problem is creation of practical detection programs for the major cancers such as breast cancer, cervical cancer, and bowel cancer that have been shown to be almost completely controllable in participants in continuing detection schemes. Meanwhile, research must continue to optimize the treatment for patients with established disease and to investigate the epidemiology of causes and high risk situations.

In support of these needs a Cancer Epidemiology Research Center has been established at the University of Iowa, appropriately in the Department of Preventive Medicine. Its charges are to keep the Iowa cancer problems under observation, to learn as much as possible about who gets what kinds of cancer, and to assist, particularly in planning and information management, in any and all efforts undertaken in the state for cancer control.





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M. E. ALBERTS, M.D., Scientific Editor

#### ANNUAL IMS SCIENTIFIC SESSION

Invitations to attend the 1974 Annual Scientific Session have been issued by Dr. Rubin H. Flocks, President of the Iowa Medical Society. This year, the 75th anniversary of the University of Iowa Hospitals, the meeting will be held in Iowa City on April 18, 19 and 20. An excellent program of interest to most physicians is promised. Subjects extend from the *top* to the *bottom* of medical interest . . . allergy and sinus problems to a consideration of ano-rectal disorders. In between there will be a discussion of the appropriate drugs that affect the mood, hypertension—renal diseases, aching backs and respiratory failure as well as many others.

#### HOSPITAL AUTOMATION

The nurses station so traditional in the hospital ward is to become a thing of the past. Like railroad depots, another meeting place is to be abandoned. Nurses and doctors meet at the nurses station for conferences regarding patients; much paper work is accomplished at this station, and in the television medical programs, the house staff and student nurses are often depicted as engaging in a bit of horse-play at this central meeting place.

The nurses station is to be replaced by an "Administrative Communications Center" (ACC) in the new addition to Mercy Hospital, Des Moines, scheduled to open in March. The ACC, manned by non-nursing personnel, is located directly opposite the passenger elevators on each level. As a physician enters a given "patient care

One might quip that if you are in the proper mood for some good postgraduate education, and the old back is aching with the load of the practice this winter, you might find the program so comprehensive as to make you breathless. There will be a presentation on "passing gas" in case that appeals to you.

If that is not enough, extracurricular activities will be available—a reception, banquet, tours, and an open house of clinical departments. Here is an opportunity for the "town and the gown" to meet, compare experiences, and learn, as well as enjoy the fellowship of friends and colleagues.

Mark your calendar—April 18, 19 and 20—the IMS Annual Scientific Session at Iowa City.—M.E.A.

level" (no longer called a ward because all the rooms are single patient units), he asks the ACC clerk to alert the Nursing Team Leader responsible for the zone where his patients are confined. The nurse is summoned by means of a pocket radio-page, and she meets the doctor at the patient room. If the physician is in a patient's room and needs a nurse, he may contact the ACC via an intercommunication unit in the patient care alcove or at the patient's bedside cabinet. ACC in turn pages a nurse. The patient charts are retained in the individual patient room to be completed there as the nurse attends the patient's needs. Orders and reports also can be transmitted to the ACC by the nurse via a mini-pneumatic tube system.

A built-in NURSERVER in the corridor wall of each patient-room will provide access to fresh supplies as well as a means of disposal of soiled items. The NURSERVER will be replenished regularly with supplies and waste and soiled items will be removed. The nurses will spend their time, for the most part, in direct bedside care of the patient, or in conference with the doctors, or in transmitting orders for tests, therapy, medications, or needed supplies not routinely available in the NURSERVER. Through selective intercommunication pathways the nurse may contact Supply, Processing and Distribution (SPD), Pharmacy, Housekeeping, and Food Services to request particular needs.

Automation in this Friesen-designed addition to Mercy Hospital becomes even more sophisticated in the manner of distribution of supplies. An Automatic Cart Transport System (ACTS) provides movement of supplies via overhead monorails and vertical lifts. All supplies used in patient care are processed at a central location (SPD) two levels below the first patient level, and are transported on carts to the "clean room" at each patient level. There is also a special priority line which has a cart or basket ready to re-

ceive "rush orders." This line interdicts and takes precedence over all other carts routinely traveling the monorail supply line.

Soiled materials on carts are returned via the ACTS "return line" to the SPD area where they are removed to a giant carousel, the core of which is a huge garbage or soiled waste disposal. Equipment or materials to be re-used are sorted from the carousel into baskets which travel automatically via roller conveyors and lifts through washersterilizers into the "clean" side for reprocessing. The carts, too, may go through an automatic washer-dryer much like an automatic car wash.

Automation again becomes more our way of life. Human energies in the hospital will be expended more for direct patient care while machines will do the routine and less-exciting tasks. As long as electric energy is available and is directed properly, the system will save many manhours of tedium with reasonable cost effectiveness. Patient care should be more direct and personal. But, will someone, please, tell me which button to push?—M.E.A.

#### ON WRITING EDITORIALS

What does it take to be in the mood to write? Sometimes words flow freely from the pen; other times the pen, as well as the thought processes, seem to have "gone dry." The most difficult part is getting started. It is said that Hemingway had a ritual of sharpening 20 pencils before writing. Some writers drink; others walk through the streets or fields to collect their thoughts or contemplate a theme.

So far I have not developed any sort of ritual before writing my editorial comments. Perhaps I should as I start my third year serving the Iowa Medical Society and our JOURNAL. Some days I find the power of the pen to be very weak and words come slow and hard. Sharpening pencils does not appeal to me. I cannot tolerate drink

adequately to have it serve a useful purpose. Walking through the streets could be disastrous to the head and the wallet. So I continue to scan many medical journals and talk to my colleagues hoping to hit upon interesting and timely topics.

Editorials can be controversial, but I like nearly everybody and do not like to become deeply embroiled in arguments. Editorials can serve to report news, and that we try to do to a degree. Editorials may comment on advances in knowledge, placing emphasis on what the breakthrough might mean to any or all of us. Also, editorials may be personal ancedotes of the writer.

Technically, an editorial presents an opinion of the editor. My opinion is that this editorial has taken up space, musing upon the task of getting started on a bit of writing, and I still do not have the answer. Thanks for staying with me, anyway.—M.E.A.

# HEW DESCRIBES PSRO IN Q&A FORMAT

THE PROFESSIONAL STANDARDS REVIEW program has given rise to a great deal of confusion in the minds of physicians who are uncertain about its purpose, about how it will work, and about its effect on their ability to provide responsible care for their patients."

This paragraph opens a recent statement made by Charles C. Edwards, M.D., Assistant Secretary for Health, Department of Health, Education and Welfare. His further comments seek to dispel some of the physician apprehension over the impending PSRO program. Dr. Edwards' total statement is contained in a PSRO question and answer folder issued by the government in December.

Issued also in December was the first major pronouncement having to do with the actual implementation of the PSRO program. On December 20 PSRO area designations were announced with Iowa included among the 26 states chosen to function as single statewide units. The designation pronouncements have prompted objections, principally from the states where multi-PSRO's are proposed. AMA has requested an extra 90 days to file comments on the designations.

The HEW folder alluded to is a sort of governmental primer on PSRO. We offer excerpts from the folder here; space limitations make condensation necessary.

#### What is a PSRO?

Professional Standards Review Organization (PSRO) is a program organized, administered and controlled by local physicians to evaluate the necessity and quality of medical care delivered in their area under Medicare, Medicaid and Maternal and Child Health programs.

# How will PSRO affect a physician's practice of medicine?

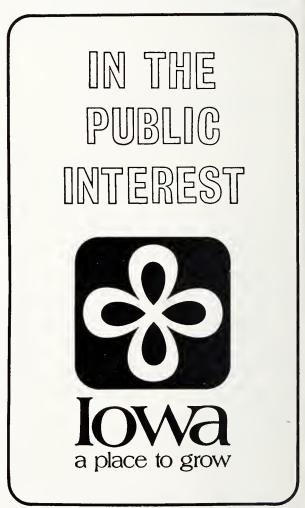
PSRO will cause little change in the way most physicians practice medicine. The PSRO program does require that the services a physician provides in institutions to Medicare and Medicaid patients be subject to review by his peers in the local PSRO. . . . As long as a physician's pattern of practice falls generally within the norms and criteria which he will help establish for his

PSRO, his practice will not be significantly affected.

# Will the PSRO's tell physicians how to practice medicine?

The local physicians who make up each PSRO will establish the standards and criteria to be used in determining the necessity and quality of care. No standard or criteria can be applicable in every situation. There will be instances in which a physician's clinical judgment will require him to deviate from the established standards and criteria without objection from the PSRO.

If a physician's peers in the PSRO disapprove a proposed procedure or service or an extension of a length of stay, the immediate effect would be that the government would not pay for those



services. The physician is still free to provide the care and services he chooses, and he can appeal the determination....

# How will standards and criteria of care to be used by a PSRO be established?

Each PSRO will establish standards and criteria of care that reflect acceptable patterns of practice in the PSRO's area and that will lend themselves to local review. It is expected that the standards and criteria used by a PSRO will be modified as experience is gained and developments in medicine warrant their modification. Norms, standards and criteria will take into account the professional personnel, facilities and equipment available. The National Professional Standards Review Council must approve norms used by a PSRO that are significantly different from professionally developed regional norms.

The national specialty societies are preparing model criteria which will be made available to the PSRO's and which they can adopt or adapt to meet local circumstances.

#### What will be the responsibilities of a PSRO?

The PSRO will determine whether services provided are medically necessary, of proper quality, and delivered in the most appropriate setting for the proper length of time. The PSRO will have the authority to approve in advance the medical necessity of elective admissions to institutions as well as extended or costly services. In carrying out its responsibilities, the PSRO will consult with other health care practitioners, such as dentists and podiatrists, for assistance in reviewing services which these practitioners provide.

# What will be the relationship between the PSRO and internal review activities in institutions?

The PSRO will accept the review performed by utilization review committees whenever the PSRO determines that such review is effective and that the physicians of the institution participate in the overall review activities of the PSRO.

# What will the PSRO do about unnecessary or improper health care services?

The purpose of the PSRO program is to improve the quality of care not to discipline physicians. If a physician's pattern of practice indicates he is delivering excessive or insufficient

health care or otherwise improperly treating his patients, his peers in the PSRO will advise the physician and recommend appropriate remedies, such as professional consultation and education. Only in rare cases would sanctions provided by law be imposed, such as suspension or termination of Medicare and Medicaid payments. Appeal mechanisms from any sanctions recommended by the PSRO are also provided by law.

#### When will PSRO's be established?

By January 1, 1974, HEW must designate PSRO geographic areas throughout the United States. Once the areas have been designated, HEW will enter into an agreement with a qualified organization in each area to be the PSRO. Until January 1, 1976, only a nonprofit, professional association representing most of the practicing physicians in an area can qualify as a PSRO. If such an organization does not apply to be a PSRO by that date, HEW can designate another organization, such as a health department or medical school, that has the professional medical competence to be a PSRO.

#### How will a PSRO be supported?

HEW will provide funding to the PSRO to cover all necessary expenses involved in carrying out its functions, including the reimbursement of physicians for time spent participating in review activities.

# Is the purpose of PSRO to assure quality or control cost?

The primary emphasis of the PSRO program is on assuring the quality of medical care. Providing quality care may increase health services for some patients in certain areas and could increase costs in those circumstances.

PSRO will be concerned also with whether medical care is necessary and delivered in the proper setting. If overuse or uneconomical use of services are identified and eliminated, cost savings will result.

A PSRO will not concern itself in any way with the fees for services charged by physicians or institutions.

These appear to be the key questions and answers from the recently distributed HEW folder. Their presentation in this manner may help to increase the understanding of PSRO. Time will be required to test the accuracy of the answers and the merits of the program.

# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

#### ANALYZING TRANSACTIONS

"I'M OK—YOU'RE OK" is the title of a book by a California psychiatrist, Dr. Thomas A. Harris. More than just "a book," it is an important book, one that will have great impact on the medical world and the world at large. You should read it. If you already have, maybe it's time to read it again. A skillful piece of technical writing for the layman, it's likely to help life be more trouble-free and rich in meaning for a large number of people who need help to reduce trouble and increase the sense of value in their lives. All of us in the medical profession need to study the principles of transactional analysis and apply them to our professional and personal lives.

I write about the book here because I'm impressed once again with the connection between the task of helping people medically, and educating them effectively. Dr. Harris makes clear that using the concept of "Parent-Adult-Child" or "OK, NOT OK" to help patients with what we lump as "emotional problems" requires us to teach patients this new vocabulary and method. To use transactional analysis as a tool to aid our patients to a more symptom-free and productive life means we must be teachers and our patients must be learners. To act with independence and

maturity, and have a secure sense of control over ourselves and our destinies means we must exhibit adult behavior and use it to control the impulses, destructive feelings, or constrictions placed upon us by excessive activity of the "child" or "parent" components of our personality.

The "therapy" offered by transactional analysis groups is really a special sort of short course about behavior and how it may be modified. Whether you call it teaching-learning, or behavior modification, it's what we as physicians are involved in a good deal of our professional time.

Whether transactional analysis and its methods will truly replace Freudian vocabulary, concepts and treatment methods, as Dr. Harris suggests, will require more time to demonstrate. But it's clear to me that whatever your area of medical work may be, you need to know what transactional analysis is about, just as you need to know about penicillin, cortisone or birth control pills.

And if you want to find out in an uncommonly interesting way, why don't you enroll in the workshop, "Transactional Analysis, The Phenomenology of Patient Behavior, and Medical Practice," which will take place at the University of Iowa's College of Medicine on March 6 and 7, 1974. The instruction and activities will be led by Dr. Gordon Deckert of The University of Oklahoma. He can provide you a lively and effective entry into the world of transactional analysis.

**HONOR DR. BEAN...** William B. Bean, M.D., U. of I. professor of internal medicine, has had a conference room named in his honor. The William B. Bean Conference Room is located in Univer-

sity Hospital's new southeast addition and is part of the Department of Medicine's educational and administrative complex. Dr. Bean headed the Department from 1948 to 1970.

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.

#### THE QUESTION BOX

(Continued from page 58)

#### How did you get started with recruitment?

The first contact with a younger physician was made through the Iowa Medical Society Physicians' Placement Service. His overseas military service prompted considerable correspondence. He was contacted immediately upon his return to the U. S. He was invited to visit our clinic and community. He, and subsequent candidates, have been encouraged to look at different locations and arrangements before making any decisions.

Wives of prospects are included in our discussions. They have an obvious and definite interest in the site selection process.

#### How do you account for your apparent success?

My patients and fellow physicians have remarked that I am lucky to have competent and able young associates. My reply is, perhaps I am lucky, but part of the luck resulted from the considerable effort expended in this direction.

#### What about the future?

The time is probably not too distant when there will be greater numbers of young physicians desiring to practice in Iowa. My hope is that the many associations will continue to grow and will be as satisfactory as the one in which I have a part.

What suggestions do you have for physicians seeking associates, as well as physicians seeking locations?

Here are a few very obvious and important steps to take:

- 1. Contact the Iowa Medical Society Physicians' Placement Service to indicate needs and desires.
- 2. Make initial contacts several months in advance.
- 3. Encourage personal visits in addition to maintaining contact by telephone and mail.
- 4. Offer adequate salary arrangements for a specified early period to see if the association will be satisfactory.
- 5. If it proves satisfactory to all concerned, the new colleague should be offered a partnership. This should come at a time when he is performing a high enough percentage of the work to warrant partnership status. The partnership assures that a new partner's after expense income is commensurate with the percentage of the work load which he is assuming.
- 6. Do not expect financial gain from the efforts of others.
- 7. Most recent graduates are top quality physicians. Never consider any one whose qualifications are doubtful.
- 8. Insist on frequent, frank discussions and honest criticism. This helps both ways.
- 9. Experience and judgment at least partially offset the superior education and training of the recent graduate. This reality can work toward the mutual benefit of the association and to the patient's benefit as well.
- 10. Iowans deserve top quality medical care. Associations of physicians, with convenient and good hospital facilities to support them, are best qualified to deliver this excellent care.
- 11. The time is approaching when there will not be a shortage of physicians. It is hoped the quality of medical education will remain top-flight. We hope too that distribution about the state will be in such a manner that all citizens will have access to excellent medical care.

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▲ Milwaukee Sanitarium { Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.

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### State Department of Health

#### CADAVER ORGAN RECOVERY

The following statement regarding the need for cadaver organs was prepared by R. L. Lawton, M.D., of the Organ Recovery and Preservation Unit at University Hospitals:

The problems of the patient with end stage kidney disease are the concern of all of us. As humanitarians and respected physicians of the community, our concern goes beyond our immediate patient group. Hardly a physician in the state is not in some way associated with a patient with end stage kidney disease, either through his immediate patients or through their families. There are over 100 patients on maintenance dialysis throughout the state (and their numbers are growing daily) who need a cadaver organ donation for survival. Eighty per cent or more of the patients who reach terminal kidney disease will not have a satisfactory living related donor.

The availability of a combination of treatments for the patient with terminal kidney disease has "caught the eye" of the public and legislators alike. Through the voluntary Kidney Foundation of Iowa, the public has supported a number of public education programs. The Foundation has devoted much of its energy to cadaver organ donation activities. The Regional Medical Program has supported organ recovery and has trained preservation technicians. The State's Chronic Renal Disease Program and Advisory Committee, founded approximately two years ago, is involved in patient care and organ recovery and preservation. The Federal Government has passed legislation which will help to fund dialysis and transplantation under Medicare. It is apparent that the plight of the patient with end stage (terminal) renal disease is the concern of all.

A survey of major cities in the state, several years ago, revealed a more than adequate number of potential cadaver organ donors for all patients in need of a kidney. Presently, we are recovering only a fraction of them. News releases in the daily press give an indication of the cadaver potential. Vital organs are a precious commodity, and the public is willing to donate the kidneys from their next of kin who have suffered cerebral death. The recovery and transplant team at the University Hospitals in Iowa City needs to know from Iowa physicians when a potential cadaver donor has experienced cerebral death as a result of severe head injury or massive stroke. The hospital and physicians involved in identifying and recovering organs on a local level will be adequately compensated. Thanks to some considerate physicians throughout the state, we have recovered organs from Council Bluffs, Waterloo, Sioux City, Davenport, Cedar Rapids, Fort Dodge, Ames and Spencer. We ask your cooperation in helping to provide for those patients who need a transplant desperately. The Recovery and Preservation Unit will be happy to help manage cerebral death cadavers in Intensive Care Units just prior to organ recovery. For information regarding organ recovery, or if you have a potential cadaver donor, please call University Hospitals Operator, collect, 319/356-1616 and ask for the Transplant "Beeper," or if this is ineffective, have the operator call R. L. Lawton, M.D. or R. C. Corry, M.D.

Over the past three years we have transplanted over 100 organs (kidneys), and our results have been very rewarding. Organ Recovery Manuals are available on request from the Organ Recovery and Preservation Office at the University Hospitals, Iowa City, Iowa 52242. Please mark your requests to the attention of R. L. Lawton, M.D.

The State Department of Health is vitally interested in assisting Dr. Lawton and Dr. Corry in

securing sufficient numbers of cadaver organs. Many patients on the transplant list in Iowa City are on hemodialysis and are being assisted by the Chronic Renal Disease Program administered by the State Department of Health. The patients' chances of receiving a kidney transplant will be tremendously improved if more cadaver organs can be obtained. Unless cadaver organs can be

made available, the patient with end stage kidney disease must continue the expensive and long hemodialysis treatment. Any questions you may have regarding this Department's Chronic Renal Disease Program should be addressed to the Director, Mr. Juris Poncius, Iowa State Department of Health, Lucas State Office Building, Des Moines, Iowa 50319; telephone 515/281-5605.

#### Morbidity Report for December, 1973

Disease	Dec. 1973	1973 to Date	1972 to Date	Most December Cases Reported From These Counties	Disease	Dec. 1973	1973 to Date	1972 to Date	Most December Cases Reported From These Counties
Adenovirus					Meningitis,				
infection	2	3		Johnson, Sioux	bacterial due				
Amebiasis	2	79	5	Dallas	to Hemophilus				
Ascariasis	1	5		Linn	influenza	3	7		Des Moines, Scott
Brucellosis	5	10	29	Linn, Tama	Meningitis,				
Chickenpox	773	12467	9450	Scattered	bacterial due				
Conjunctivitis	91	1049	875	Scattered	to Neisseria				
Cytomegalovirus					meningitidis	2	2		Muscatine, Story
infection	2	7		Johnson	Mumps	482	4095	6986	Crawford, Hancock,
Eaton's agent									Jones, Tama
infection	6	32	5	Johnson, Polk, Poweshiek, Scott, Story	Padiculosis	29	216	21	Dubuque, Linn, O'Brien, Webster
Enteropathogenic	:				Pertussis	1	21		Davis
E. Coli	4	10		Buena Vista, Linn,	Pinworms	2	13		Marshall, Polk
				Muscatine, Polk	Pneumonia	128	1195	1012	Scattered
Erythema					Rabies in animal	5 6	214	350	Scattered
infectiosum	2	344		Black Hawk, Warren	Rheumatic fever	2	17	32	Winnebago
Gastrointestinal					Ringworm, body	14	142	113	Scattered
viral inf.	1039	7653	8061	Scattered	Ringworm, scalp	- 1	5		Lee
Giardiasis	1	22		Johnson	Roseola	2	8		Black Hawk, Marion
Hepatitis,					Rubella	2	221	464	Hardin, Osceola
infectious	4	220	293	Cerro Gordo, Des Moines,	Rubeola	2	284	1114	Mahaska, Marshall
				Guthrie, Polk	Salmonellosis	18	227	94	Scattered
Hepatitis, serum	1	50	51		Scabies	7	236	2	Cerro Gordo, Dubuque,
Herpes simplex	12	83		Cedar, Johnson, Linn	•••••				Johnson, Muscatine
Histoplasmosis	1	- 11	26	Cass	Shigellosis	7	275	561	Dubuque, Linn, Warren
Impetigo	50	476	529	Scattered	Streptococcal	•			
Infectious					infections	913	7435	6791	Scattered
mononucleosis	117	786	1022	Linn, Story	Tuberculosis.	/13	7433	0,,,	Scarrence
Influenza-like					active	9	125	117	Scattered
illness	1188	14690	655	Benton, Johnson, Linn,		-	123	117	Scalleled
				Warren	Venereal Disease		(401	(107	Scattered
Meningitis, type					Gonorrhea	515	6481	6197 496	Scattered Scattered
unspecified	3	35	32	Black Hawk, Scott,	Syphilis	23	415	470	Scarrered
				Wapello	Visceral larva				A4 1 II
Meningitis assoc					migrans	ı	1		Marshall
with mumps	- 1	2		Hancock	Whipworm inf.	I	- 1		Muscatine

#### **Medical Assistants**

by TENORA MEYER, CMA

#### PATIENT RAPPORT

Medical assistants must routinely establish rapport with patients, salesmen and fellow employees. Some people have the gift of charisma while others must strive hard to develop this intangible asset.

The appearance of an office reflects its efficiency and the character of its regular inhabitants. A clean orderly office with warm decorative accents will help patients feel at ease.

Patients deserve to be greeted warmly. The medical assistant can do much to put the patient at ease before seeing the physician.

In telephone communications, we must be careful to avoid "playing down" the patient's problem. His complaint is very real to him, and unlike you, he is not looking at his symptoms in an objective manner. If we ask about symptoms and use common sense in answering, we should get the basic information needed to decide if the patient is really in acute distress and should be seen immediately, this can then be relayed to the physician. The patient should also feel you are genuinely interested in his problem. After he has had an opportunity to explain how he feels, the average patient usually becomes more receptive than when he first telephoned to demand an appointment "today." Your good judgment must help you determine whether this is an emergency or not, and if you lack that judgment you must refer the call to your busy physician to decide the question. We must talk calmly and courteously on the telephone even though it is virtually "ringing itself off the hook." Good patient communication is crucial.

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

Letters to patients reflect your method of operation. The accomplished medical assistant will save the physician many hours by her ability to handle routine business letters. First, she will choose an appealing form, after consulting the physician for his personal preference. She will then make sure all letters include full titles, addresses, including zip codes, and references so they will move without delay and convey the desired message. She will remember the three magic concepts: clarity, courtesy and brevity. Physicians are of necessity in the business world but they are keenly aware their "image" must never be that of a hard, driving, aggressive businessman. The business letter from a physician, therefore, will get to the "heart of the matter" but it should also carry a graciousness to enhance the physician "image."

The medical assistant who develops an effective but pleasant method of collecting for office visits will be an asset to any physician. There are medical assistants who may have a high percentage of collections, but because of their cold, unfeeling manner and their limited regard for the patient's financial problems, they are held in low esteem. They may actually be resented by the patient and this naturally reflects upon the physician. The need for medical care is seldom anticipated. Illness usually strikes suddenly and finds the average person financially unprepared. A concern for the patient's health and situation can be very helpful in collecting and much more effective than a cold, indifferent manner.

Finally, honor the patient's communication with you. Respect the privacy of your work and protect the patient and your physician by never discussing either a patient or the work of your physician with anyone.



When the patient on anticoagulant therapy has a condition requiring an analgesic, a new problem arises. Aspirin frequently causes prolonged bleeding time and occult gastrointestinal bleeding. 1.2

TYLENOL (acetaminophen) however, is unlikely to produce either reaction<sup>2,3</sup> and is therefore the preferred analgesic for the patient with hemorrhagic tendencies and the patient receiving anticoagulant therapy.

The patient on anticoagulants is only one of several 'types for

TYLENOL'-that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Koch-Weser, J., and Sellers, E.M.: New Eng. J. Med. 285:447-458 (Sept. 2) 1971. 2. Udall, J.A.: Clin. Med. 77:20-25 (Aug.) 1970. 3. Mielke, C.H., Jr., and Britten, A.F.H.: New Eng. J. Med. 282:1270 (May 28) 1970 (corresp.).

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# About IOWA Physicians

Dr. Gordon E. Rahn, only living charter member of Linn County Chapter (formed in 1950) of American Academy of General Practice, became a charter fellow of the American Academy of Family Physicians at the 25th annual Scientific Assembly in Denver. . . . Dr. Walter Block, medical director, Cedar Rapids Child Evaluation Clinic, spoke on "The Brain and How It Works," at CR seminar sponsored by the Clinic. Dr. William Bell, professor of pediatrics and child neurology at U. of I. College of Medicine, also participated in the seminar.

Dr. Lloyd H. Koelling, Newton physician for 25 years, has opened the Arizona Institute of Hypnosis in Scottsdale, Arizona, following completion of residency at the American Institute of Hypnosis in Los Angeles, California. . . . Dr. and Mrs. Leo H. Kuker, Carroll, recently attended the Sixth International Congress of Abdominal Surgeons in Munich, Germany, Dubrovnik, Yugoslavia, and Florence, Italy. Dr. Kuker is president of the American Society of Abdominal Surgeons. . . . Dr. Patrick Bosley has joined the Muscatine Community Health Center to do family practice. A native of Great Britain, Dr. Bosley attended St. Georges Hospital Medical School in London. He has been an honorary research fellow for the Department of Neurological Research, University of British Columbia, Vancouver, Canada, and served two years on the teaching staff of the Medical School of the University of West Indies. Since 1966, Dr. Bosley has been in general practice in Balaton, Minnesota. . . . Dr. J. F. Wubbena, Rock Rapids, and Dr. J. G. Lavender, George, are conducting a 14-week course on intensive coronary care for registered nurses and licensed practical nurses at Merrill Pioneer Community Hospital. . . . Dr. John Garred, Whiting,

was recently honored by the residents of Whiting, Sloan, Saliz, Hornick, Sergeant Bluff and Onawa at a "Dr. John Garred Appreciation Night," sponsored by the Whiting Community Club. A plaque was presented to Dr. Garred in recognition of his 25 years of medical service in the area. . . . Dr. Peter Jerome has joined the Bettendorf Medical Center to practice internal and general medicine. For the past 13 years, Dr. Jerome has been associated with the Davenport Clinic.

Dr. B. Frank Vogel, Cherokee, is new Director of Clinical Services at the Mental Health Institute in Cherokee. Dr. Vogel joined the MHI staff in 1970. . . . Dr. Michael Crane recently joined Dr. Don N. Orelup in family practice in Albia. Dr. Crane received the M.D. degree at U. of I. College of Medicine in 1970 and interned at Broadlawns-Polk County Hospital in Des Moines. He formerly practiced medicine in Nevada. . . Dr. Donovan Ward, Dubuque, has been reappointed to the AMA Council on Legislation. . . Dr. Najed Chaarani, Shenandoah, is new Fellow of American College of Chest Surgeons. Dr. Chaarani is also a Fellow of American College of Surgeons and International College of Surgeons.

Dr. Robert M. Kretzschmar, associate professor in Department of Obstetrics and Gynecology at U. of I. College of Medicine, is new president, Iowa Division, American Cancer Society. He was also nominated recently to National Board of Directors of American Cancer Society. . . . Dr. Ted E. Hoff, Jr., ophthalmologist, Dr. Ruben Altman, internist, and Dr. Ronald L. Bendorf, psychiatrist, recently entered private practice in Council Bluffs. Dr. Hoff received the M.D. degree at University of Nebraska College of Medicine in 1966; interned at Clarkson Hospital in Omaha; and had an ophthalmology residency at Wilford Hall

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Hospital at Lackland AFB, Texas. Prior to locating in Council Bluffs, Dr. Hoff was staff ophthalmologist at Keesler AFB, Mississippi. Dr. Altman received his medical training at Georgetown and Harvard Universities and was formerly chief cardiologist at Andrews Air Force Base in Washington, D. C. Dr. Bendorf is a 1962 graduate of the University of Nebraska College of Medicine and served his residency at the Nebraska Psychiatric Institute. He has served two years on the faculty at University of Nebraska College of Medicine. . . . Dr. Clarence Denser, Des Moines, has been renamed to the AMA Committee on Quackery. He will serve until 1975. . . . Dr. James L. Knott, Council Bluffs, is new president of the Southwest Division of the Iowa Heart Association. Dr. Knott will be responsible for coordinating heart programs for a 17-county area.

Dr. R. Bruce Dunker, Mason City, has been elected a Fellow of American College of Obstetricians and Gynecologists. Dr. Dunker received the M.D. degree at U. of I. College of Medicine and served his ob-gyn residency at Brooke Army Hospital in Texas. . . . Dr. Robert B. Stickler, Des Moines, was elected to the Board of Governors of American College of Surgeons at the organization's recent annual Clinical Congress. . . . Dr. Alfred Friedrichsen has joined Dr. Burns Byram in the family practice of medicine at Marengo. A 1972 graduate of U. of I. College of Medicine, Dr. Friedrichsen interned at William Beaumont Hospital, Detroit, Michigan. Dr. Friedrichsen's wife is also a physician and is a resident in urology at the U. of I. College of Medicine. . . . Dr. Terry Dynes, Decorah, was named member of Iowa Regional Advisory Group at annual meeting of Iowa Regional Medical Program.

Dr. Reginald R. Cooper has been appointed head of Department of Orthopedics at U. of I. College of Medicine. He has served as acting head since July. . . . Dr. Hormoz Rassekh, Council Bluffs, has been named by Governor Robert D. Ray to the Mental Hygiene Committee of the State of Iowa. The committee is concerned primarily with

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the various community mental health centers in the state.... Dr. John K. Uchiyama, Des Moines, has been elected a member of the American College of Physicians.... Dr. Asghar Syed, a native of India, has joined the Clarinda Mental Health Institute staff. Dr. Syed received the M.D. degree at Karachi, Pakistan. He interned at Deaconness Hospital in St. Louis, and served a four-year psychiatric residency at St. Louis State Hospital. He had a fifth year of residency at Buffalo State Hospital in New York. Dr. Syed was formerly staff psychiatrist at Community Mental Health Center, Albert Einstein College of Medicine, Bronx, New York.

Dr. Adrian Flatt, professor of orthopedic surgery at U. of I. College of Medicine, was guest speaker at recent Wapello County Medical Society meeting. Dr. Flatt, who utilizes stainless steel hinges in severely arthritic finger joints, discussed "Problems in Surgery of the Hands." . . . Dr. Robert Cozine, Emmetsburg, was guest speaker at first class of "Facts and Fallacies of Aging," an

adult education course for senior citizens.... Dr. Julius Connor, director of Des Moines-Polk County Health Department, was guest speaker at recent meeting of Fifth District Iowa Nurses Association in Iowa City.... Dr. Thomas Updegraff, Waterloo, has been named an adjunct professor of speech pathology at the University of Northern Iowa.... Dr. R. J. Fisch, LeMars, has joined Medical Associates. He has been a solo practitioner in LeMars for many years.

Dr. David A. Culp, professor and vice chairman of Department of Urology at U. of I. College of Medicine, is new president of the North Central Section of American Urological Association. He is also chairman of the audio-visual education committee and a member of the council on education of AUA. In addition, he serves on the executive committee of the Section on Urology of American Medical Association. . . . The following Sioux City physicians have been named officers of St. Vincent Hospital medical staff—Dr. Paul A. Fee, president; Dr. John J. Dougherty, vice-

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president; and **Dr. Sidney A. Cohen**, secretary-treasurer. . . . **Dr. N. L. Saxton** has closed his medical practice in Oskaloosa to become an assistant professor at Texas Tech's School of Medicine in Lubbock, Texas. Dr. Saxton will teach clinical medicine to third and fourth year medical students. A 1961 graduate of U. of I. College of Medicine, he practiced in Oskaloosa for 10 years. . . . **Dr. Jon Wubbena**, Rock Rapids, was guest speaker at a recent meeting of Merrill Pioneer Hospital Auxiliary. Dr. Wubbena, director of coronary care for the hospital, explained new equipment in the coronary care unit.

Dr. Hans U. Zellweger, professor of pediatrics at U. of I. College of Medicine, is president-elect of the American Academy of Cerebral Palsy.... Dr. K. J. Marshall and Dr. C. S. Tam have combined their medical practices in Washington. Dr. Marshall was formerly associated with Drs. G. J. Nemmers and E. M. Ahart. The merger will allow the two physicians to rotate night and weekend calls.... New officers of medical staff at St. Joseph's Mercy Hospital in Sioux City are—Dr. Gerald J. McGowan, president; Dr. Daniel M. Youngblade, vice-president; and Dr. V. G. Kirkegaard, secretary-treasurer.... Dr. Glenn C.

**Blome**, Ottumwa, retired from active practice of surgery January 1. Dr. Blome came to Ottumwa in 1933.

Dr. Walter Block, Cedar Rapids, has been given the "Helping Hand" award of the Iowa Chapter of the Association for Children with Learning Disabilities. The award is the highest given for professional contributions to the learning disabilities program. Dr. Block has been director of the Child Evaluation Clinic in Cedar Rapids for eight years. The award was presented at a recent meeting of the state association in Des Moines. ... Dr. Ismael M. Naanep, Des Moines, has been elected to Fellowship in American College of Obstetricians and Gynecologists. . . . Dr. Donovan Schmidt, D.O. has joined Drs. James Carr, James Young and Patrick Kain in the family practice of medicine in New Hampton. Dr. Schmidt is a 1969 graduate of the Des Moines College of Osteopathic Medicine and Surgery. . . . Dr. Robert Joranson has been named president of Pottawattamie-Mills County Medical Society; Dr. Edward Farrage, president-elect; Dr. K. A. Birusingh, vice-president; and Dr. D. O. Minchin, secretary-treasurer. All are Council Bluffs physicians. . . . Dr. T. E. Jessen joined the Jasper County Medical Center in January. A 1968 graduate of U. of I. College of Medicine, Dr. Jessen comes to Newton from Coralville where he has been in general practice the past 3½ years.

Dr. Charles E. Schaefer has been elected to fellowship in American College of Surgeons. . . . Dr. Earl Bickel has been elected president of medical staff of Mercy Hospital in Cedar Rapids. Other new officers are: Dr. John Barthel, president-elect; and Dr. John Puk, secretary-treasurer.

#### **DEATHS**

Dr. Kenneth R. Cross, 58, died December 12 at Mercy Hospital in Iowa City. A 1939 graduate of U. of I. College of Medicine, Dr. Cross was chief of laboratory service at Veterans Hospital in Des Moines from 1946-1951 when he was named chief of laboratory service at VA Hospital in Iowa City. He was instrumental in founding the School of Medical Technology at Veterans Hospital, and served as school's director from 1952-1971. He had also practiced pathology at Mercy Hospital since 1965, serving as chief of staff at the hospital in 1967-1968, and was co-director of Cross Medical

Laboratories in Iowa City. In addition, Dr. Cross was clinical professor of pathology at U. of I. College of Medicine and professor of medical technology in the College of Liberal Arts. He was a past president of Iowa Association of Pathologists and the Johnson County Medical Society, and was member of Iowa Medical Society and American Medical Association.

Dr. James E. Murtaugh, 68, New Hampton, died October 22, 1973, at Rochester, Minnesota. Dr. Murtaugh received the M.D. degree at Loyola University in Chicago in 1933. A family practitioner in New Hampton since 1942, Dr. Murtaugh was Chickasaw County Medical Examiner and Chief of Staff at St. Joseph's Hospital. He was a member of Iowa Medical Society and American Medical Association.

Dr. B. Raymond Weston, 79, Mason City, died October 25 at a Mason City Hospital. Dr. Weston received the M.D. degree at Rush Medical School in Chicago, and began his Mason City medical practice in 1920. He was a charter member and past president of the board of directors of the Charles H. MacNider Museum; past president of Winnebago Boy Scout Council, Rotary Club, Cerro Gordo County Medical Society, and St. Joseph's Mercy Hospital staff. Dr. Weston was the first recipient west of the Mississippi of the Boy Scout Silver Beaver award. He was a member of the International and American Colleges of Surgeons, American Medical Association and a life member of the Iowa Medical Society.

#### INDEX TO ADVERTISERS

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Dean's Camper Sales
Emergency Medical Associates
Flint Laboratories
Iowa Trust Association
Lilly, Eli, & Company 45, 60
McNeil Laboratories
Marion Laboratories
Medical Protective Company
Milwaukee Sanitarium Foundation
Nebraska Psychiatric Institute 82
Pharmaceutical Manufacturers Association 54D, E
Prouty Company 83
A. H. Robins Company 54A, B, C
Roche Laboratories 46-47, 87-88
Searle, G. D., & Co
Smith Kline & French Laboratories 66A
Tahiti Tour 51

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ROBERT D. WHINERY, M.D. G. FRANK JUDISCH, M.D.

2409 TOWNCREST DRIVE IOWA CITY, IOWA 52240 TELEPHONE 319/338-3623 hen you determine that the lepressive symptoms are associated vith or secondary to predominant nxiety in the psychoneurotic atient, consider Valium (diazepam) naddition to reassurance and ounseling, for the psychotherapeutic upport it provides. As anxiety is elieved, the depressive symptoms eferable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. mprovement generally becomes vident within a few days, although

some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

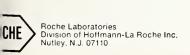
Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

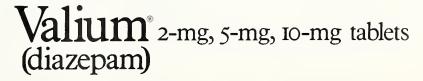
# ymptom complex Valium (diazepam)

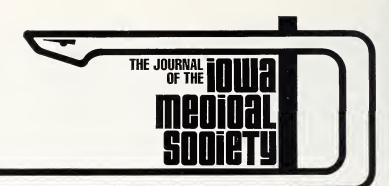
Precautions: If combined with psychotropics or anticonvuls, consider carefully pharmaty of agents employed; drugs as phenothiazines, narcotics, iturates, MAO inhibitors and antidepressants may potenits action. Usual precautions ated in patients severely desed, or with latent depression, th suicidal tendencies. Observe I precautions in impaired renal

or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.







VOL. 64 No. 3 MARCH, 1974

	TABLE OF CONTENTS		lowa Medical Miscellany	103
	1974 IMS Scientific Session	94	Educationally Speaking	106
	Mediastinal Myxoma: A Case Report		The Question Box	119
	Sudhir Jaituni, M.D., M. S. K. Arkee, M.D., and James M. Caterine, M.D., F.A.C.S.	107	State Department of Health	120
Lawyers' Contingent Fee—Protection for			Medical Assistants	22B
	Physicians		In the Public Interest	123
	Earl F. Rose, M.D., LL.B.	111	About Iowa Physicians	125
	Supplemental Security Income Program Homer E. Wichern, M.D.	114	Deaths .	127
	EDITORIALS		MISCELLANEOUS	
	New Reporter for Family Physicians	117		
	Cataract "Roto-Extractor"	117	Approve Degrees	106
	Cataract "Roto-Extractor"		Approve Degrees  To Expand Health Sciences Information	
			To Expand Health Sciences Information .  Continuing Education Courses and Confer-	113
	Random Thoughts at an Airport	118	To Expand Health Sciences Information .  Continuing Education Courses and Confer-	113

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Address all communications to the Editor of the Journal, 1001 Grand, West Des Moines, Iowa 50265.

Postmaster, send form 3579 to the above address.



The ensnarling nature of governmental minutia really boggles the mind and tests the temperament. It is endangering America's vitality. Private economy appears beleaguered by questionable governmental impositions on its modus operandi. Manufacturers talk forlornly about OSHA and various governmental edicts or burdens which make expansion or even maintenance of the status quo a questionable proposition.

Medicine finds itself similarly dismayed and apprehensive and continually uneasy about government's next move. For example, in January, HEW issued a new regulatory proposal calling for mandatory pre-admission certification for Medicare and Medicaid hospital patients. HEW says prior approval of non-emergency admissions must be given



by hospital UR committees. Economy is the intent. As this is prepared, there's been no final word about final adoption or implementation. Heaps of critical comment have come from medical ranks. AMA has advised it will seek an injunction to stay the regulation.

PSRO conjures up much uncertainty as we step to its threshold. Protection—to the fullest extent possible—of the profession and the public has been the objective of your Society officers and staff as the PSRO chapter of health care history is written. It's a formidable, time-consuming and costly proposition. But we need to be in the foray, as actively as possible.

Sincerely,

Rubin Flocks, M. D.

Rubin Flocks, President



APRIL 18, 19, 20, 1974 IOWA CITY, IOWA

THE 1974 IOWA MEDICAL SOCIETY PROGRAM COM-MITTEE IS PLEASED TO INVITE YOUR CONSIDERATION OF THE SCIENTIFIC PROGRAM DESCRIBED ON THE FOLLOWING PAGES. THIS IS A DIVERSIFIED CONTINU-ING EDUCATION EVENT OPEN TO ALL SOCIETY MEM-BERS. WE SINCERELY HOPE YOU WILL ATTEND.



R. D. WHINERY, M.D., Chairman Iowa City



R. M. CAPLAN, M.D.



L. J. GUGLE, M.D.



C. P. HAWKINS, M.D.



J. F. MURPHY, M.D. Boone



H. J. SMITH, M.D. Des Moines



J. E. TYRRELL, M.D. Manchester



S. E. ZIFFREN, M.D. lowa City

#### THURSDAY, APRIL 18-IOWA MEMORIAL UNION

11:00 A.M.—REGISTRATION

SECOND FLOOR, BALLROOM LOBBY

1:00 P.M.—THE MEDICAL COMMUNITY AND THE UNIVERSITY OF IOWA

BALLROOM, SECOND FLOOR



RUBIN H. FLOCKS, M.D. President lowa Medical Society



WILLARD L. BOYD President The University of Iowa



JOHN W. ECKSTEIN, M.D. Dean The University of Iowa College of Medicine

# 1:15 P.M. SOME OPPORTUNITIES & ISSUES IN MEDICINE

Ballroom, Second Floor



ROBERT C. MARSTON, M.D.

Charlottesville, Va.

Dr. Marston is a former Director of the National Institutes of Health. He is now Scholar-in-Residence at the University of Virginia, and the first Distinguished Fellow of the Institute of Medicine at the National Academy of Sciences. Dr. Marston was recently named President of the University of Florida, a post he will assume in the summer of 1974.

# 1:45 P.M.—AGRICULTURAL MEDICINE

Ballroom, Second Floor



TRAUMA PROBLEMS

L. W. KNAPP
Assistant Director
University of lowa
Institute of Agricultural Medicine



EYE INJURIES & ANHYDROUS AMMONIA

JAY H. KRACHMER, M.D. Assistant Professor Ophthalmology



PESTICIDE TOXICOLOGY

DONALD P. MORGAN, M.D. Director
Community Pesticide Project
Institute of Agricultural Medicine

INJURIES TO EXTREMITIES BRUCE SPRAGUE, M.D.

Assistant Professor Orthopaedic Surgery

#### 3:00 P.M.—COFFEE BREAK

Ballroom Fover

# 3:15 P.M.—SHIRTSLEEVE DISCUSSIONS



DISCS, MUSCLES, ACHING BACKS

Michigan Room/Third Floor

CARROLL B. LARSON, M.D. Professor Orthopaedic Surgery



OFFICE GYNECOLOGY

Illinois Room/Third Floor

ROBERT M. KRETZSCHMAR, M.D.

Associate Professor Obstetrics & Gynecology



WHICH DERMATITIS IS WHICH?

Ohio State Room/Third Floor

RICHARD M. CAPLAN, M.D. Professor

Dermatology



APPROPRIATE USE OF THE DRUGS THAT AFFECT MOOD

Lucas-Dodge Room/Second Floor

RICHARD FINN, M.D. Associate Professor Psychiatry



MANAGING ACUTE ALLERGIC REACTIONS

Grant Wood Room/Second Floor

H. B. RICHERSON, M.D. Associate Professor Psychiatry



MORE HELP FOR COMMON ANO-RECTAL DISORDERS

Northwestern Room/Third Floor

WENDELL DOWNING, M.D.

Private Practitioner Des Moines

#### 4:05 P.M.—SHIRTSLEEVE DISCUSSIONS WILL BE REPEATED

Repeat Previous Hour

#### 5:00 P.M.—ADJOURNMENT

6:30 TO 8:00 P.M.

# RECEPTION FOR PHYSICIANS & WIVES AT THE HIGHLANDER RESTAURANT

SPONSORED BY THE U. OF I. ALUMNI ASSOCIATION & THE COLLEGE OF MEDICINE

#### FRIDAY, APRIL 19-UNIVERSITY HOSPITALS

#### 8:00 A.M.—REGISTRATION

Medical Alumni Auditorium/E331

# 8:30 A.M.—INTERDISCIPLINARY WORKSHOPS

The Workshop topics, locations and program coordinators are listed. Other participating faculty members will be introduced at the time of the sessions.



PRACTICAL CARE OF BURNS

Frank Peterson Conference Room/I-E

#### CHARLES HARTFORD, M.D.

Associate Professor Surgery Director of Burn Unit

- The Burn Problem
- Fluid Resuscitation of the Acutely Burned
- Inhalation Injury
- Infection in Burn Patients & Survival Results
- Surgical Management of Burn Wound (Film)
- Management of Contractures and Scars
- Office Management of Small Burns
- Emotional Aspects of Thermal Injury
- Q & A Panel



#### CORONARY ARTERIOGRAPHY & SURGERY

Medical Alumni Auditorium/E331

#### CARL W. WHITE, M.D.

Assistant Professor Internal Medicine

- Natural History of Angina Pectoris
- Modern Approach to Evaluation of Angina Patient
- Coronary Arteriography: Techniques, Results, Limitations

- Saphenous Vein Bypass Surgery
- New Horizons in the Surgical Treatment of Coronary Artery Disease
- Panel Discussion: Management of the Pre-Infarction Syndrome

#### PERIPHERAL VASCULAR DISEASE—EXTRA-CRANIAL CEREBRAL VASCULAR DISEASE

Wm. Bean Conference Room/3-SE



Wm. H. BAKER, M.D.



E. J. WHYLIE, M.D.

Dr. Baker is an associate professor of surgery. Dr. Whylie is a visiting professor at The U. of I. and is a professor of surgery, and chief of the vascular surgery service at the University of California Medical Center in San Francisco.

- Recognition and Non-Surgical Treatment of Transient Cerebral Ischemia
- Cerebrovascular Insufficiency; Indication for Surgery
- Panel Discussion
- Presentation of Illustrative Cases



THE PROBLEM OF BREAST CANCER

Urology Conference Room/4-SE

#### STANLEY G. KORENMAN, M.D.

Professor Internal Medicine Director, Division of Endocrinology

- Who Gets Breast Cancer? Epidemiology
- Viruses and Breast Cancer
- New Diagnostic Procedures
- Rationalization of Treatment of Metastatic Disease
- Open Discussion

#### 10:15 A.M.—COFFEE BREAK

# 10:30 A.M.—WORKSHOPS CONTINUE



#### HYPERTENSION OF RENAL ORIGIN

Urology Conference Room/4-SE

DAVID CULP. M.D.

Professor and Vice Chairman Urology

Dr. Culp will be assisted by Annette Fitz, M.D., who is an associate professor in the Department of Internal Medicine.

- Introduction, Historical, Conditions Where Hypertension Appears in Renal Disease, Pathophysiology of Renal Hypertension, Identifying Clinical Manifestations of Renal Hypertension
- Diagnostic Modalities, Electrolyte & Pharmacologic Findings, Roentgenographic Findings, Differential Renal Function Tests
- Indications for Surgery and Results, Renal Vascular, Nephrectomy
- Medical Therapy
- Presentation of Illustrative Cases/Discussion
- Q and A Session

#### PERINATOLOGY

William Bean Conference Room/3-SE



HERMAN HEIN, M.D.



CHAS. WHITE, JR.,

Dr. Hein is director of the Statewide Perinatal Care Program. Dr. White is a professor of obstetrics and gynecology.

- Indications & Techniques for Use of Oxytocin
- Patient Selection for Anniocentesis
- Essentials of Resuscitation for the Newborn
- Newborn Jaundice and Use of Bililights
- Problem Prevention With the Newborn: Use of Oxygen, Maintenance of Infant Warmth and Early Feeding
- Q & A Session



#### MANAGEMENT OF RESPIRATORY FAILURE

Medical Alumni Auditorium/E331

#### GEORGE N. BEDELL, M.D.

Professor, Internal Medicine Director, Pulmonary Disease Unit

- Diagnosis of Respiratory Failure
- Use of Oxygen in Respiratory Failure
- Indications for Tracheostomy and Methods for Assisted Ventilation
- Fluid Management in Respiratory Failure
- Weaning from the Respirator
- Management of Infection in Respiratory Failure
- Q & A Session



#### MEDICAL & SURGICAL MANAGEMENT OF OBESITY

Frank Peterson Conference Room/I-E

#### EDWARD E. MASON, M.D.

Professor Surgery

- Questions: How? Why? Results? Dangers?
- Group Therapy & Hypnosis
- Medical Management
- TOPS
- Weight Watchers
- Diet Instruction
- Intestinal Bypass
- Gastric Bypass
   Panel Discussion

#### 12:15 P.M.—LUNCH BREAK

The Doctors' Dining Room/University Hospitals will be available to physicians and wives.

#### 1:15-4:00 P.M.—OPEN HOUSE/ CLINICAL DEPARTMENTS

Physicians are welcome to visit any clinical department. Problems brought by visiting physicians will be discussed. Programs will range from relatively structured presentations to informal consultations and conferences about particular problems. Please check in at the Department Office.

#### DEPARTMENT OF ANESTHESIA

General Hospital/6th Floor East Use East Elevator Only

- Patient Presentations
- Consultant's Corner: Problems in Anesthesia, Respiratory Care and Intensive Care

#### DEPARTMENT OF DERMATOLOGY

Children's Hospital

Patient Presentations

#### DEPARTMENT OF FAMILY PRACTICE

Oakdale Campus—One mile north of Int. 80 on U.S. Hwy 218

- Special Audit Conference re Record Keeping Techniques
- Patient Presentations

#### DEPARTMENT OF INTERNAL MEDICINE

General Hospital/3rd Floor East

• Grand Rounds

#### DEPARTMENT OF NEUROLOGY

General Hospital/4th Floor Center

• Patient Presentations

# DEPARTMENT OF OBSTETRICS & GYNECOLOGY

General Hospital/4th Floor West

- Oncology Ward Rounds
- Grand Rounds
- Panel Discussion: Endocrine Problems

#### DEPARTMENT OF OPHTHALMOLOGY

General Hospital/2nd Floor West

• Grand Rounds

## DEPARTMENT OF ORTHOPAEDIC SURGERY

Children's Hospital

- Trauma Clinic
- General Clinic

#### DEPARTMENT OF OTOLARYNGOLOGY

General Hospital/2nd Floor East

• Patient Presentations

#### DEPARTMENT OF PEDIATRICS

General Hospital/Room C-132

- Clinical Ward Rounds
- Neonatal Intensive Care Unit
- Patient Presentations

#### DEPARTMENT OF RADIOLOGY

General Hospital/7th Floor Tower

• EMI Scanner

#### DEPARTMENT OF SURGERY

General Hospital/Ist Floor East

- Trauma Conference
- Grand Rounds

#### DEPARTMENT OF UROLOGY

General Hospital/4th Floor East

• Patient Presentations

#### ADDITIONAL ACTIVITIES

Special tours will be arranged of the Medical Center Art Museum and Hancher Auditorium. Physicians and thei wives will also have access to recreational facilities.

IOWA MEDICAL SOCIETY BANQUET
AT THE HIGHLANDER RESTAURANT
6:00 P.M.—SOCIAL HOUR (CASH BAR) 7:00 P.M.—DINNER
THE ALL-MEDICAL SCHOOL BIG JAZZ BAND

#### SATURDAY, APRIL 20-IOWA MEMORIAL UNION

#### 8:00 A.M.—BREAKFAST ROUNDTABLES

FIRST FLOOR-MAIN LOUNGE

Advance registration will be required for these Dutch-treat one-hour breakfast discussions.

I—TRANSFUSION REACTIONS

2—FAMILY PLANNING

JOHN A. KOEPKE, M.D.

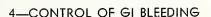
Professor & Vice Chairman Pathology CHARLES A. dePROSSE, M.D.

Assistant Professor
Obstetrics & Gynecology



3-BIO-MEDICAL ETHICS

DAVID A. BELGUM, Ph.D.
Professor
College of Medicine and School of
Religion



WILBUR ZIKE, M.D. Assistant Professor Surgery



5—MANAGING URINARY TRACT INFECTION

DAVID CULP, M.D.
Professor and Vice Chairman
Urology



6—PROGRESS IN COMBATTING DEAFNESS

LEE A. HARKER, M.D.
Assistant Professor
Otolaryngology & Maxillofacial Surgery



7—THE CHRONIC LUNGER: WHAT ANESTHETIC & OPERATIVE RISKS?

AZMY BOUTROS, M.D.
Professor
Anesthesia



8-ACUTE CARDIAC FAILURE

LOTFY L. BASTA, M.D. Assistant Professor Internal Medicine



9—DOES "ALLERGY" REALLY CAUSE "SINUS TROUBLE"?

PAUL SEEBOHM, M.D. Associate Dean and Professor Internal Medicine



10—SURGICAL PROCEDURES
IN MEDICAL EMERGENCIES

KENNETH PRINTEN, M.D. Associate Professor Surgery



II—PROBLEM SOLVING— FLUIDS & ELECTROLYTES

EDWARD MASON, M.D. Professor Surgery

#### 9:05 A.M.—GENERAL SESSION

Second Floor Ballroom

# BIOLOGICAL & CLINICAL CONSIDERATIONS OF BREAST CANCER MANAGEMENT



BERNARD FISHER, M.D.

U. of I. Visiting Professor Professor of Surgery School of Medicine University of Pittsburgh

# UNIVERSITY OF IOWA COLLEGE OF MEDICINE PROGRESS REPORTS



FAMILY PRACTICE EDUCATION

ROBERT RAKEL, M.D. Professor & Head Family Practice



MUSCATINE COMMUNITY HEALTH CENTER & THE PHYSICIAN'S ASSISTANT PROGRAM ARTHUR HORSLEY, M.D. Assistant Dean

Assistant Dean Community Health & Allied Health Programs



NEUROLOGY

ADOLPH SAHS, M.D. Professor & Head



COMMUNITY-BASED CONTINUING EDUCATION

RICHARD CAPLAN, M.D. Assistant Dean Continuing Medical Education



OBSTETRICS & GYNECOLOGY

WILLIAM KEETTEL, M.D. Professor & Head



# 10:15 A.M.—WHAT'S NEW IN MEDICINE?

**ANESTHESIA** 

MARTIN SOKOLL, M.D. Professor



OPHTHALMOLOGY

ROBERT WATZKE, M.D. Professor & Head



**DERMATOLOGY** 

CHRISTIAN RADCLIFFE, M.D. Professor & Head



ORTHOPAEDIC SURGERY

REGINALD COOPER, M.D. Professor & Head



FAMILY PRACTICE

ROBERT RAKEL, M.D. Professor & Head



OTOLARYNGOLOGY & MAXILLOFACIAL SURGERY

LEE HARKER, M.D. Assistant Professor



INTERNAL MEDICINE

JAMES CLIFTON, M.D. Professor & Head



PATHOLOGY

JOHN KOEPKE, M.D. Professor & Vice-Chairman



**PEDIATRICS** 

FRED SMITH, M.D. Professor & Head



RADIOLOGY

JAMES CHRISTIE, M.D. Professor & Head



PREVENTIVE MEDICINE & ENVIRONMENTAL HEALTH

PETER ISACSON, M.D.
Professor & Head



SURGERY

SIDNEY ZIFFREN, M.D. Professor & Head



**PSYCHIATRY** 

GEORGE WINOKUR, M.D. Professor & Head



UROLOGY

RUBIN FLOCKS, M.D. Professor & Head

# II:45 A.M.—REPORT FROM THE PRESIDENT RUBIN H. FLOCKS, M.D.

President Iowa Medical Society

#### Noon—ADJOURNMENT

#### **ACCREDITATION**

The Iowa Medical Society 1974 Scientific Session is accredited for 10 hours (Category I) by the American Academy of Family Physicians.

#### See Next Page for Additional Program Details

#### REGISTRATION

ADVANCE: Physicians are urged to register in advance for the two scheduled meal functions: (1) Scientific Banquet Friday night (\$10 per person)—(2) Breakfast Roundtables Saturday morning (\$2.50 per person). A registration form and reservation envelope is included with a special 1974 Scientific Session mailing which all member physicians will receive. The registration forms should be returned as soon as possible.

AT MEETING: Registration will begin at 11:00 a.m., Thursday, April 18, and continue throughout the meeting. All physicians and wives should register at the IMS Registration Desk, Second Floor, Iowa Memorial Union. Registration will be available Friday, April 19, at 8:00 a.m. outside the Medical Alumni Auditorium/E331, University Hospitals.

#### LODGING

Blocks of rooms have been reserved for IMS members at the lowa House/Iowa Memorial Union and at several motels. Room reservations and assignments will be handled through the Convention Center/Iowa Memorial Union.

#### EMERGENCY CALLS

On Thursday and Saturday emergency calls should be directed to 319/353-5505. On Friday calls should be directed to 319/353-5763.

#### **PARKING**

Unreserved parking near the Iowa Memorial Union is usually scarce on Thursdays and Fridays. Ample free parking is available north of the Union on Saturday. Parking in the ramp adjacent to the Union is provided to Iowa House guests without charge. For those not staying at the Iowa House, a reserved ramp parking permit may be obtained at the IMS registration desk.

#### SPECIAL ACTIVITIES

Special tours of the medical center, general campus, art museum, and Hancher Auditorium will be available to interested persons. Recreational and athletic activities will be available: golf (Finkbine Course), swimming, archery, badminton, handball, jogging (Fieldhouse), billiards, table tennis, sauna bath (Recreational Building), tennis (indoor and outdoor courts). Arrangements may be made through the IMS Convention Center.

#### SPECIALTY MEETINGS

The following specialty organizations have scheduled meetings and functions on Saturday, April 20, following the IMS Scientific Session:

IOWA ACADEMY OF SURGERY
IOWA PSYCHIATRIC SOCIETY
IOWA UROLOGICAL ASSOCIATION
IOWA ASSOCIATION OF PATHOLOGISTS

#### FOR THE LADIES

During the three-day meeting physicians' wives will have the opportunity to hear Charles Johnson, M.D., of the Child Development Clinic at The University of Iowa College of Medicine, discuss "Child Abuse." Mrs. Martha Fry, Clinical Research Head Dietitian, Department of Nutrition, will speak on "What a Doctor's Wife Should Do in Her Own Home to Provide a Low Cholesterol Diet."

Wives of physicians are welcome to attend any portion of the scientific program which is of particular interest.

The Spanish Room, located in the Iowa Memorial Union, will provide a convenient place for relaxation during the meeting. Coffee and refreshments will be available.

#### SPECIAL THANKS

The following companies have provided educational grants to the Iowa Medical Society to support the 1974 IMS Scientific Session. Appreciation is extended to these organizations:

BLUE CROSS/BLUE SHIELD BRISTOL LABORATORIES ELI LILLY & COMPANY MEAD JOHNSON & COMPANY MERCK SHARP & DOHME MERRELL-NATIONAL LABORATORIES PARKE, DAVIS & COMPANY A. H. ROBINS COMPANY SEARLE EDUCATION SYSTEMS SMITH KLINE & FRENCH LABORATORIES E. R. SQUIBB & SONS, INC. THE UPJOHN COMPANY WINTHROP LABORATORIES

Appreciation is also extended to Blue Cross/Blue Shield for sponsoring the coffee functions for physicians and their wives, and to The University of Iowa Alumni Association and College of Medicine for hosting the Thursday night reception.



PHASE 4... Continues to be a vexing proposition. AMA has litigation in process to thwart discriminatory impact on physicians' fees. Hope also exists the Economic Stabilization Program may not be extended when it expires April 30. Current stipulations include 4% limit on aggregate weighted price increase for a physician's practice; a 10% limit on the increase of any individual service or procedure; a restriction on margin revenue increases; an allowance for fee increases possible but not taken; maintenance of price schedules for inspection and posting of a sign advising of such schedule. A guide on Phase 4 is available from IMS Headquarters.

**NEW COUNCILOR...** For District III is Donald F. Rodawig, Jr., M.D., Spirit Lake. He replaces John F. Rhodes, M.D., Pocahontas, who's become an alternate delegate to AMA.

continuing medical education . . . Is subject of report to Iowa General Assembly made by Board of Medical Examiners. IMS Committee on Medical Education and Hospitals was praised in January by Society's Executive Council for its support of the Board in this effort. Report urges Assembly to embody in any legislation authority for Board to devise program which provides for minimum 150 CME hours over 3-year period.

PROFICIENCY CHECK . . . Of laboratories in physician's offices is possible through evaluation program offered by College of American Pathologists. Program was endorsed in January by IMS Executive Council on recommendation of Committee on Independent Laboratories. Folder about the program is available from IMS Headquarters.

**DISTRIBUTION...** Of AMA Current Procedural Terminology (CPT) will be made to all Iowa physicians under plan of Blue Shield and IMS. This is first step in extended project to convert BS claims handling from 4-digit to 5-digit

CPT coding system. Hope is eventually claim coding may be done in physicians' offices. In same area, education program has been approved to gain physician acceptance of filing fee schedule voluntarily with Iowa Foundation for Medical Care and/or Blue Shield.

CUSTOMARY PROFILES . . . Will be derived from a statewide determination of charges by specialty (exclusive of the U. of I.) on approval of the IMS Executive Council. Blue Shield has been urged to make this move which is in line with action of the 1973 House of Delegates.

ALCOHOLISM . . . Activities were supported at January meeting of IMS Executive Council. Approval was given a tentative pilot alcoholism treatment project to involve Blue Cross/Blue Shield, Waterloo's Schoitz Hospital and the Northeast Commission on Alcoholism. Outpatient attention by certified counselors will be emphasized. Endorsement was also given treatment guides devised by the Committee on Alcoholism.

HEALTH PLANNING . . . Activities were reported to the Executive Council in January. IMS Committee on Delivery of Health Services has analyzed a plan for the State of Iowa developed by the Office of Comprehensive Health Planning. Comments submitted by the committee to OCHP noted the plan's reference value; they additionally supported local planning, cited certain health care priorities, and offered IMS cooperation in orderly evaluation of a "changing system of health care delivery."

STUDENT MEDICAL SOCIETY . . . Has received approval of its articles of incorporation and by-laws from the IMS Judicial Council. Formal approval of the U. of I. student medical society charter will be requested of the House of Delegates in May.

#### IOWA MEDICAL MISCELLANY

(Continued)

MEDICARE BOOST . . . Is scheduled in July with monthly Part B premium increasing by 40 cents to \$6.70 a month.

**HMO...** Educational program for physicians is being explored by Society staff with the Director, Health Maintenance Organization Division, Health Facilities Service, State Department of Health.

CARDIOVASCULAR STUDY . . . Opportunities are available to Iowa physicians. Intensive coronary care seminars will be offered at the U. of I. College of Medicine March 25-28 and May 6-9. Additionally, one-week specialized training workshops in cardiology are available: in the coronary care unit, the cardiac catheterization laboratory, the cardiac noninvasive laboratory and the EKG lab. For information, contact Carl W. White,

M.D., Department of Internal Medicine, The University of Iowa.

STATEWIDE CONFERENCE... On Emergency Medical Services is scheduled March 26-27 at the Hyatt House in Des Moines. Meeting is sponsored by Governor's Council on Emergency Medical Services. Martin Keller, M.D., Director, Community Health, Ohio State University, will be the keynoter. A. H. Downing, M.D., Des Moines, is the IMS representative to the EMS Council.

**RECORD PERFORMANCE** . . . Record performance has again been achieved by the Scanlon Foundation in its medical student loan program. 42 Iowans are receiving loans this academic year totalling \$62,200.

OPEN OFFICE... The Iowa Diabetes Association has an office open at the Iowa Lutheran Hospital in Des Moines from 10 a.m. to 2 p.m. weekdays. Free literature and other information are available on request. The telephone number is 515/265-6662.

#### At Your Service in The Hawkeye State

In "the land where the tall corn grows" and is called The Hawkeye State\* in honor of Chief Black Hawk of the Black Hawk War of 1832 . . .



is represented by . . .





Lee Gutermuth



Fred Hastie



Ray Holm



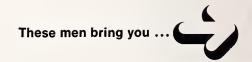
Shelby Sharpe



Chris Shibel



Steve Troxel



<sup>\*</sup>For more information on the history of your state, write Professional Services, Marion Laboratories, Inc.

UCR... Straight UCR coverage at Blue Shield through October 1973 totalled \$2,399,268 in charges with \$2,281,469 allowed in payments for a payment percentage in excess of 95.

**RENAL DISEASE...** Modifications have been made in state rules and regulations pertaining to financial assistance through the Chronic Renal Disease Program. Now, apparently, the Renal Disease Advisory Committee and the State Department of Health have discretionary authority to exceed the previous \$4,000 limit on monetary help to an individual in need of renal disease treatment.

PSYCHIATRIC CARE... Profile of psychiatric care delivery in Iowa has been compiled recently by the Iowa Psychiatric Society. A survey summary has been provided to Blue Cross/Blue Shield as an outgrowth of late November meeting between IMS Subcommittee on Psychiatric Care and BC/BS officials.

FIRST RESIDENT . . . Martha Capizzi, M.D., is the first resident in the Iowa Lutheran Hospital's

Family Practice Residency Program. It is hoped the new program will expand to accommodate 12 physicians by 1976. Dr. Capizzi is a native of Calexico, California.

NEW X-RAY SYSTEM . . . A \$350,000 x-ray scanning system has been installed at University Hospitals to make it the fifth hospital in the country to have the sophisticated diagnostic equipment. The EMI Scanner System, as it is called, allows viewing, for the first time, of the human brain in cross section.

FIRST RESOLUTION . . . For consideration by the IMS House of Delegates in May has been received by the Des Moines-Louisa Counties Medical Society. Resolution urges repeal of PSRO and calls for optimum participation in local voluntary peer review.

**SPORTS MEDICINE...** Conference for coaches, trainers, interested physicians will be April 4 at Des Moines YMCA. IMS Committee on Sports Medicine is the conference coordinator.

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# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

# DID MEDICAL SCHOOL TURN YOU OFF?

A recent article (UNIVERSITY OF MICHIGAN MEDICAL CENTER JOURNAL 39: 1-5, 1973) suggests our patterns and techniques of education in medical school over the recent decades have generated many physicians whose curiosity and educational initiative have been blunted or even totally destroyed by the educational climate they endured during medical school. The author points to irrelevant facts, excessive assignments, inter-course competition, ambiguous test questions, tedious kilo-hours of lecture, seemingly sadistic grilling at the bedside, and so on. By the simplest acquaintance with Pavlovian conditioning, we could predict that in such an environment some individuals would become well trained to avoid diligently any further contact with the "learning environment."

The article cites a study undertaken by the University of Michigan that found 3% of that state's physicians subscribing to no medical journal, and 21% devoting less than one hour weekly to reading medical literature. Since learning can be accomplished by many ways besides reading, I'd wish to know if those par-

ticular non-readers used alternative methods. But even if a certain number were indeed turned off, how can we know for sure that it was their medical course that delivered the coup de grace? Nonetheless, teachers of medicine in any setting should be well aware, as they go about their educational tasks, of the power and hazard of negative conditioning.

I sometimes wonder if there are any completely turned-off physicians out there, and if so, is there any way to turn them on again? Happily, it seems to me, the present world of medical continuing education is far more appealing than the lecture and text-book grind which still characterizes too much undergraduate medical education. Self-evaluation tests, patient management problems, short courses with carefully selected topics and the cream of the crop of speakers, audio tapes, telephone conferences, home-study courses, vacation-andlearn opportunities by the hundreds, individualized traineeships—all these seem to me a thoroughly tasty carrot. Of course, there may remain a few who just don't like carrots, even when tasty. No matter how glowingly I describe the modern world of continuing education, the person I need to reach is of course not reading these words. And you who have read this far are obviously not among the "turned-off" group. Well, better to light a candle than burn your fingers holding a match!

 $\operatorname{Dr}$ , Caplan is Assistant Dean, Continuing Medical Education at The U, of I. College of Medicine.

#### APPROVE DEGREES

Board of Regents approval has been given the University of Iowa to grant Bachelor of Science degrees to graduates of new programs in biomedical engineering and physician assisting. It is expected the new degrees will be awarded in the 1974-75 academic year. The physician's assistant program began at the U. of I. in September 1972, with support from the National Institutes of Health.



# Mediastinal Myxoma: A Case Report

JDHIR JAITUNI, M.D.,
I. S. K. ARKEE, M.D., and
AMES M. CATERINE, M.D., F.A.C.S.
es Moines

case of a mediastinal myxoma is described. Convoversial and rare nature of tumor is acknowledged. hesis here is that myxomas are true neoplasms with efinite morphologic and biologic patterns originating from primitive mesenchyme.

A MEDIASTINAL MYXOMA is indeed a rare tumor, nd its true nature has been controversial. A legenerative process has been suggested by some nvestigators, while others have postulated that t is a true neoplastic process. There are few documented cases of myxoma, mainly due to the conusion about its nomenclature. Stout, 1, 2 after an laborate study of 149 cases, came to the conclusion myxomas are true neoplasms, of unicentic origin, from mesenchymal tissue, which reproduce with some degree of accuracy the appearance of primitive mesenchyme. It is made up

Dr. Jaituni is a resident in pathology at Mercy Hospital. Dr. Arkee was a surgical resident at the Veterans Administration Hospital. Dr. Caterine is in the private practice of surgery in Des Moines.

of loose-textured, slimy tissue, composed of stellate cells set in a stroma of exceedingly delicate reticulin fibers and a mucoid substance which is probably hyaluronic acid. The following case is reported.

#### CASE REPORT

Clinical History:

A 51-year-old male was admitted to Mercy Hospital February 24, 1973, for evaluation of a large mass on the left side of the chest found on a chest X-ray obtained during a check-up for shortness of breath. His symptoms included palpitation, fullness on the left side of his chest, aching and shortness of breath. These appeared several months earlier, apparently following a common cold. Accordingly, he denied any history of cough, dyspnea, wheezing, hemoptysis, or weight loss.

On admission, physical examination revealed a well-developed, well-nourished white male, who apparently was not in any acute distress. There was what appeared to be an obvious dextrocardia with a visible pulsation throughout the right anterior chest. Percussion of the chest wall revealed a stony dullness and markedly decreased breath sounds on the left side. The liver was palpable three fingers below the right costal margin, but no peripheral edema was detected. During hospitalization, chest X-ray, fluoroscopy of the chest, cardiac series, tomography of the chest, as

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTII OF MARCH, 1974.

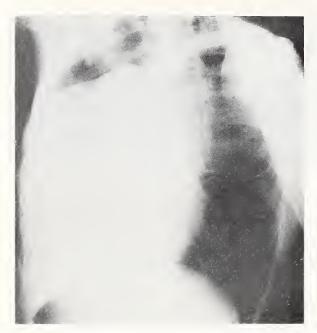


Figure 1. Roentgenogram of chest before surgery.

well as pericardial scan, were performed, all suggestive of a mediastinal mass with compression of a large portion of the left lung, with shift of the mediastinum to the right and deviation of the esophagus posteriorly and laterally. A thoracic aortogram was performed. It revealed an intact aorta bearing no relation to the previously described mass, but it did show displacement of the distal portion of the thoracic aorta to the right.

Laboratory data on admission: EKG, normal sinus rhythm with displacement and rotation of the heart; hemoglobin, 17.4 gm; hematocrit, 49.8; WBC, 11,700, with 76% segs and 23% lymphs. Urinalysis was within normal limits; creatinine was 1.5 mg, but the BUN was high, 51 mg%, which dropped to normal value later. The total proteins were 7 gm, albumin 5.3 gm, serum cholesterol 250 mg, and total bilirubin 1 mg. Alkaline phosphatase, LDH, and SGOT were within normal limits.

On March 6, 1973, a left thoracotomy was performed. Upon opening the left pleural cavity, about 200 mg of yellowish fluid was aspirated and a huge ovoid, hard mass was found. The mass occupied the left hemithorax with complete displacement of the heart to the right and compression of the lung tissue. The tumor appeared as a smooth, whitish-gray, glistening capsule, which could be peeled off anteriorly but was densely adherent to the thoracic aorta and pericardium posteriorly. When a biopsy specimen was taken

from the anterior surface of the tumor for froz section, it was found to have a cortex of 4 to mm in thickness and was filled with muco semitransparent, gelatinous, soft material. Sir the frozen section report was suggestive of myxo atous tumor and with regard to benignam size, and severe adhesion of the tumor posterior to the thoracic aorta and pericardium and lob lated structure of the tumor, it was resected me easily lobe by lobe. A left lower lobectomy we performed because of the fixation of the tumor that portion of the lung.

The compressed lung tissue was well expand after resection of the tumor, and the chest was closed after the anterior and posterior chetube were placed in position. The patient need blood transfusions postoperatively and also diveloped fever for a few days but was finally dicharged on March 27, 1973, in afebrile and googeneral condition. Since discharge, follow-rechest X-rays have shown the mediastinum to limits normal position, with the lungs clear. It has returned to his full employment without restriction.

#### Pathology Report:

The total weight of the tumor was 3,405 gr and the largest dimensions were 30 by 29 by cm. The consistency varied from soft to firm. appeared to be composed of gelatinous, tran lucent, slimy, pinkish-red tissue. Some areas r vealed intense congestion. The tumor was su mitted in lobules, and some of the lobules had well-defined capsule on the periphery.

Microscopically, the tumor was found to be hypocellular neoplasm showing a small number of stellate cells. No mitotic figures or nucleo were observed in the nuclei. Abundant amour of mucoid stroma was present, in which the celwere loosely scattered. On the periphery, fibros was evident. Mucoid stroma stained red wit Meyer's mucicarmine stain. The sections from the lung revealed pleural fibrosis, atelectasis, an bronchiectasis.

#### DISCUSSION

As described by Stout,<sup>1, 2</sup> in the study of 14 cases and later by others<sup>3</sup> (Attar and Enzinger) myxomas are neoplasms with definite morphologic and biologic patterns. They are made up of well-differentiated cells, having stellate shape an fine protoplasmic processes, suspended in a abundant loose matrix of mucoid material. Th

protoplasmic processes lie alongside the delicate reticulum fibers, coursing through the stroma. Occasionally, fibrosis can be seen on the periphery due to pressure moulding. But no other cellular elements should be identifiable. The cellular component is scanty, and mucoid stroma predominates. When acetic acid is added, it coagulates and can be dissolved by hyaluronidase, a reaction suggesting the nature of mucoid stroma. This substantiates the theory that myxomas originate from primitive mesenchyme, as the latter is rich in hyaluronic acid. Mesenchyme is present in the embryo as Wharton's jelly, to which myxomas bear close histologic resemblance. It has been proposed by Herbut,<sup>5</sup> Senn<sup>6</sup> and others that this is a normal step in the growth of mesenchymal tissue, where it develops into myxomatous tissue consisting of a gelatinous substance with scanty cells. When this tissue develops into connective tissue, the fibrous cells become abundant at the expense of mucinous substance. If a group of cells become arrested at an early stage of development, they can proliferate to form tumorlike myxoma. But if the development is arrested at a later stage, the cells can proliferate to form a connective-tisue, tumorlike fibroma.

Myxomas do not metastasize, except the controversial cardiac myxomas, the nature of which has been the subject of much discussion. Neoplastic granulomatous and degenerative processes have been implicated by various authors.

Myxomas are found equally in both sexes and at all ages, including a congenital case reported by Leitao.<sup>7</sup> The most common site of occurrence, after the heart, is the subcutaneous tissues, especially fingers, buttocks, etc. The genitourinary system is next most commonly involved, with the urinary bladder as the most common site of affliction, especially in children. Bones are commonly affected, jaws showing maximum frequency. The mediastinum is one of the rarest locations (Schlumberger<sup>8</sup>). Very few cases have been reported, including those by Lemon,<sup>9</sup> Heur, Andrus,<sup>10</sup> Barkely, and Cardoza.<sup>11</sup>

As in our case, patients remain asymptomatic for a prolonged time, because of the soft and yielding consistency of the tumor. The growth of the tumor is slow but may expand suddenly after trauma. It is known to attain enormous size. The largest tumor, recorded by Jones, 12 in 1937, in a woman, weighed 5,426 gm and was retroperitoneal.



Figure 2. Gross appearance of the tumor removed at surgery.



Figure 3. A close-up view of the tumor, showing characteristic slimy appearance grossly.

Myxomas grow by local infiltration into the soft tissue, while they produce osteolytic lesions in bones. Myxomas are very notorious for local recurrence, but with great probability this is due to inadequate excision. Treatment is surgical extirpation, with removal of generous amounts of surrounding apparently healthy tissue to insure



Figure 4. Microscopic appearance of the tumor.

prevention of "recurrence." Radiotherapy has not been found to be rewarding. It is important, therefore, to take a biopsy in suspected cases and then plan a complete excision. Prognosis is good when treatment is early and adequate.

#### SUMMARY

A case of a mediastinal myxoma, which occurred in a 51-year-old male, was presented with a review of the literature. Although the nature of mediastinal myxoma has been controversial the case reported herein indicates that mediastinal myxomas are true neoplasms with definite mor-

phologic and biologic patterns originating from primitive mesenchyme. Myxomas in general do not metastasize, although local infiltration and recurrence have been observed frequently. They are composed of stellate-shaped cells with fine protoplasmic processes suspended in abundant loose matrix of mucoid material. The prognosis is generally good when the tumor is completely excised surgically.

#### REFERENCES

The references noted in this article may be obtained from either the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

# Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

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# Lawyers' Contingent Fee-Protection for Physicians

EARL F. ROSE, M.D., LL.B. Iowa City

The Lawyers' contingent fee is a favored subject for physician criticism. Medical societies have even proposed resolutions to condemn the lawyers' contingent fee system for promoting and multiplying unfounded medical malpractice lawsuits. That the contingent fee effectively screens medical malpractice cases is difficult for physicians to understand for, as a group, physicians are often quick to believe the worst that can be said of litigation and law. Physicians tend to be hostile to lawyers, especially plaintiff's lawyers, although most will admit that some of their best friends are lawyers.

The contingent fee is a method of compensating a lawyer for representing a plaintiff (patient) in a malpractice lawsuit. Contingent fee arrangements are customarily used by trial and probate lawyers and in some real estate transactions. The fee is based on a clearly understood contract between the plaintiff and his lawyer whereby the lawyer receives a percentage, usually 35% or one-third, of the damages awarded the plaintiff if the case is won. Thus, the contingent fee is contingent on winning. Whatever the percentage the attorney charges, he gets nothing if his client does not win. In addition, if the case is lost, the attorney gets nothing for his time, and yet must pay in full for all the expensive overhead costs. If the case is won, approximately 38% of the award goes to the plaintiff, 35% to the plaintiff's attorney, and 27% is used up for investigatory expenses, court costs and fees (including expert witness fees to physicians).2

#### ACTUAL PROTECTION

Thus the system of contingent fees actually protects the physician from weak malpractice claims, for the physician need only remember what the plaintiff's attorney is painfully aware of—35% of nothing is nothing. Indeed, it is in the good lawver's office that many frivolous, insignificant, emotion-fraught, or otherwise unsound malpractice claims are weeded out. The 1969 report of Senator Ribicoff's subcommittee on medical malpractice, citing a study of the California Medical Association, said, "The study concludes that lawyers perform a useful function in screening out many wholly unwarranted cases."3 A startling and paradoxical criticism of the contingent fee system, and by implication criticism of both physicians and lawyers, was made by the 21member Federal Commission on Medical Malpractice established in 1971 by President Nixon.4 This commission concluded the contingent fee arrangement actually discouraged meritorious claims against physicians for malpractice when there existed the prospect of only a small recovery. In this instance it would appear the disdain of the legal profession for a small fee works to the advantage of the negligent physician—no cause for respecting either.

The increase in malpractice litigation is the result of much more than the contingent fee. The real intent, of course, is to compensate the patient for medical injury, i.e., harm to the patient incurred in the course of treatment whether through negligence or otherwise. Were it not for actual and continuing cases of patient injury while under medical care, the current history of litigation could not have been built to its present and expanding size. Most malpractice suits are based on a medical "result," the alleged injuries following medical treatment or surgery. It is here where the pa-

Dr. Rose is a professor in the Department of Pathology at The University of Iowa College of Medicine.

tient customarily finds grounds for bringing legal action. The litigation then is to determine if there was "fault" or "malpractice" in the medical care. It is axiomatic that physicians do not guarantee a cure or a good result, but merely promise to practice that standard of medical care expected of a reasonable physician in that community or a like community. However, it takes more than an injury to prompt a patient to sue his physician. First, there is a national trend for individuals to seek redress for grievances in the courts. Second, malpractice suits are the indirect result of the changing nature of the physician-patient relationship. The image of today's doctor is different from what it used to be. The increasing demands for medical care cause many physicians to be overworked and pressed for time, resulting in less time per patient and an increase in the potential for error. The patient may feel ignored and even neglected under these circumstances.

#### COST CONCERNS

Fertile ground exists for a malpractice suit when the physician sends a bill the patient thinks excessive. An outstanding defense lawyer, representing physicians and hospitals in malpractice litigation and a frequent speaker at medically sponsored conventions and medicolegal symposia, stated: "It is common knowledge today that almost all doctors are making enormous amounts of money, refuse to make house calls, play golf on Wednesdays, drive expensive cars, own boats, hunting lodges, and apartment houses. . . . "5 This unpopular image of the affluent physician is not calculated to create a great deal of sympathy for him in the mind of the ordinary and reasonable juror. Nevertheless, even in notorious California, the physician wins nine out of 10 cases. And indeed, as physicians, we recognize there is an incidence of human error in providing medical care and a need to improve current methods of redressing the injured patient. To depend upon the lawyers' contingent fee system for unjust protection from malpractice litigation offends our sense of justice.

Alternative methods of compensating the patient injured while under medical care include "no fault" insurance and medical malpractice mediation panels. Panels designated

by interprofessional committees representing the bar association and the medical association have on occasion been organized to resolve these problems and to help clear court calendars. The patient's medical complaint is assigned to appropriate medical practitioners, and they in turn make recommendations regarding the merit of the case. These panels may or may not function as mediators in the settlement discussion. Unfortunately, panels of physicians may be coerced into the expanded role of resolving judicial and legal issues and no longer function as experts providing medical information and opinions to aid the trier of fact in reaching a legal decision. The adversary system is the backbone of American justice, and, as said by Associate Justice Harlan, "Our scheme of ordered liberty is based, like the common law, on enlightened and uniformly applied legal principles, not on ad hoc notions of what is right or wrong in a particular case."6

#### NO-FAULT APPROACH

"No-fault" insurance systems to compensate patients suffering harm, whether through physician negligence or not, have been touted as one alternative to the traditional lawsuit based on the tort of negligence. This type of legislation is similar to the proposed Uniform Motor Vehicle Accidents Reparations Act in which victims of automobile accidents are reimbursed for injuries and losses, but denied a right of recovery for non-economic detriment (human misery, pain and suffering). Under this system the injured patient would receive reparations to the extent of his injury, and "fault" or "negligence" is not a consideration. The limits of reparations, if any, included under such a mandated coverage raise a number of vital questions. Perhaps there should be no limit on benefits for medical, hospital, and related expenses, but a decision as to the extent of coverage includes the issue of reimbursement for all economic loss sustained. These related benefits include compensation for work loss, replacement services loss, survivor's economic loss, and perhaps even funeral benefits. Certainly a high benefit package with high deductibles would cover the few cases of exceptional injury, but have the potential disadvantage of leaving a large percentage of injured patients with no recovery at all. The cost of covering all losses at both ends of the spectrum would run insurance rates well beyond their present level.

At the present time it is true that in some areas a medical specialist must pay as much as a fifth of his gross revenue in premiums for malpractice insurance, but the average cost for all physicians is a bit under 2% of gross income. Perhaps the best argument against abandonment of private malpractice insurance is a consideration of the administration of nofault insurance. The physician is faced here with a government administered or supervised program, and physicians with a sense of history should not look on governmental supervision with a great degree of affection—particularly since physicians are members of a minority profession with modest individual and collective political clout.

#### NOT PRINCIPAL FACTOR

The contingent fee may be a convenient and misunderstood scapegoat for the physician. However, it is not the fundamental problem which burdens him with malpractice premiums and litigation. This is borne out in Britain for although British law does not countenance the contingent fee for the plaintiff's lawyer, there has been a substantial increase in the damages and costs paid out by the British Medical Defense Union<sup>8</sup> and the Medical Protection Society,<sup>9</sup> although the number of cases does not approach the num-

ber filed in the United States. In addition, U. S. statistics show the doctor usually comes out the winner in the courtroom, and the law gives the doctor the protection of requiring expert medical testimony by his physician peers before a judgment of malpractice can be obtained (except in an obvious case such as amputating the wrong leg).

Thus the advocacy system, the contingent fee, and private malpractice insurance all work to the physician's benefit. Physicians with an intense interest in the lawyers' contingent fee system may wish to expand existing federal and state regulations which either limit the amount of fee to be charged or require agency approval prior to payment. Generally this intervention into the amount of the lawyers' fees has involved such relatively specialized legal areas as workmen's compensation, Veterans Administration matters, or federal loans. At the present time the contingent fee agreements are being reviewed more and more by the courts in an effort to keep them at a reasonable level or to reduce the lawyer's percentage. Physicians wishing to become involved in setting lawyers' fees will no doubt find the lawyers willing to return this professional courtesy by establishing physicians' fees-and there are more lawyers who are legislators than there are physicians.

#### REFERENCES

The references noted in this article are available from either the author or the journal of the iowa medical society,

# TO EXPAND HEALTH SCIENCES INFORMATION

A \$74,295, three-year grant to increase the availability and accessibility of health sciences information throughout Iowa has been awarded to The University of Iowa by the National Library of Medicine.

Robert W. Cryder, U. of I. health sciences librarian, will head the project to establish a network by which health sciences personnel throughout the state may obtain needed information. It is anticipated libraries will be established in more hospitals with efforts being made to coordinate the programs of several small hospitals within an area.

Efforts to upgrade libraries were pursued actively between 1970 and 1972 through a statewide Health Science Library Advisory Committee. Ed Holtum has been appointed library services coordinator and will work especially with small hospitals to continue the programs initiated by the Advisory Committee. He expects to provide information to county medical societies.

## Supplemental Security Income Program

HOMER E. WICHERN, M.D. Des Moines

A new Supplemental Security Income Program became operative in January. It replaces the past tederal-state programs of public assistance payments to the aged, blind and disabled.

ALL INDIVIDUALS connected with the nation's Social Security and Public Assistance Programs have come to realize they work in an environment where change is relatively constant. They have seen great strides made in the development of programs through new and changing legislation. These programs are intended to meet the needs of people and answer the pressing problems of our time.

Recent amendments in the Social Security Act have produced some far-reaching changes in the nation's Social Insurance and Public Assistance Programs. The most recent legislation passed by the United States Congress and signed by the President is the Supplemental Security Income Program. The new program replaces the past federal-state programs of public assistance payments to the people who are aged, disabled, and blind.

The new Supplemental Security Income Program affords for the first time in this country an entirely federally financed and administered assistance program. The new program will allow a nationwide base of income for those disabled and blind who meet the eligibility requirements. It is designed to provide financial assistance to needy

people who are disabled or blind. Responsibility for administration of the new program has been given to the Social Security Administration. Benefits under the Supplemental Security Income Program will be obtained from the Federal General Revenue Fund, and not from the Social Security Trust Fund.

Under the new program there will be uniform federal definitions of disability and blindness. The definitions of disability are the same as those now used in the Social Security Disability Insurance Program. It should be noted, however, that there is no lower age limit, and an infant or child who meets the definition of disability or blindness and the tests of income and resources shall be eligible for benefits.

The Supplemental Security Income Program is part of a comprehensive plan to help the aged, blind, and disabled in partnership with the states. The intent is to allocate to each level of government, state and federal, those responsibilities and functions it is best able to perform. The states may then concentrate on improving social and rehabilitation services.

Under the Supplemental Security Income Program, uniform national eligibility requirements replace the multiplicity of requirements in the federal-state welfare programs for the aged (over 65), blind, and disabled which were formerly administered by state and local welfare agencies. Those individuals who apply for SSI benefits and are over age 65 will be handled entirely by the Social Security District Offices, as medical determinations of disability will not be required for those applying for benefits who are over age 65. Our office, the Disability Determination Division, will handle only those claims involving the disabled and blind who are under age 65.

The Supplemental Security Income Program supports and enhances the personal dignity of those who will receive its benefits. People may receive benefits while retaining a level of home ownership and other personal property. Liens will not be taken on their homes. The federal law

Dr. Wichern is chief medical consultant, Rehabilitation and Services Branch, Disability Determination Division. Inquiries may be directed to him at 1115 Bankers Trust Building, Des Moines, Iowa 50309.

will not interpose a provision of relative responsibility that would serve to disqualify a person otherwise eligible for benefits. The new program became effective nationwide on January 1, 1974.

Under the new Supplemental Security Income Program, we will be relying heavily on the Iowa medical community for supportive medical evidence on their patients who apply for benefits. We are required to place appropriate emphasis on the supportive medical evidence supplied by physicians. This evidence is essential in making a sound determination.

The same State agency handling the Social Security Disability Program will also be responsible for the development and adjudication of the Supplemental Security Income Program. Supplemental Security Income claimants will apply for benefits through the Social Security Office as they do in the Social Security Disability Insurance Program. The Social Security representative will take their applications and determine if they meet the technical requirements of the law.

The applications of those claimants (disabled and blind) who meet the technical requirements of the law will be forwarded to the State Agency. The State Disability Determination Division will, through their adjudicative process, make determinations of eligibility for those claimants applying for benefits. Generally, the Supplemental Security Income disability determinations will be made under the same basic policies and evaluation criteria used in the Social Security Disability Program. The same standards of medical disability will have to be met in the SSI Program as they do now in the Social Security Disability Insurance Program.

The Social Security Program encourages persons to return to gainful employment whenever possible. At the time a person's disability claim is processed, he is also considered for Vocational Rehabilitation Services. All persons filing disability claims, whether or not they are found eligible for benefits, will be considered. Those who have rehabilitation potential are referred to the State Vocational Rehabilitation Agency. Services include counseling, guidance, teaching of new employment skills, medical services, training and job placement. Many disabled persons have been able to return to work after receiving rehabilitation assistance.

#### ORTHOPAEDIC & REHABILITATION SEMINAR

Twelfth Annual Orthopaedic and Rehabilitation Seminar presented by the Younker Memorial Rehabilitation Center, Iowa Methodist Hospital, and the Iowa Orthopaedic Society will be March 22-23 at Johnny and Kay's Hyatt House in Des Moines.

Treatment of Flexor Tendon Injuries and Re-Implantation of Severed Fingers—Harold E. Kleinert, M.D., Medical School, University of Louisville.

Experiences With Total Shoulder Replacement—William H. Bickel, M.D., Mayo Clinic, Rochester, Minnesota.

Advances in Orthotics—Newton C. McCollough, M.D., School of Medicine, University of Miami, Miami, Florida.

For additional information, contact Department of Physical Medicine and Rehabilitation, Younker Memorial Rehabilitation Center, Iowa Methodist Hospital, Des Moines. Conference topics and speakers include:

Cadaver Demonstration of Repair of Chronic Ligamentous Injury to the Knee & Shoulder and Elbow Injuries in Athletics—Stanley L. James, M.D., Orthopaedic and Fracture Clinic, Eugene, Oregon.

Results of Early Motion in Flexor Tendon Surgery—Arnis Grundberg, M.D., Des Moines.

Results of Total Knee Replacement—Hebert, Marmour, Polycentric and Concentric Techniques —Richard Johnston, M.D., John Kelley, M.D., and Joe Fellows, M.D., Des Moines, and William Baird, M.D., Ames.

Electromyography After Laminectomy—Richard Materson, M.D., School of Medicine, Ohio State University.

Orthoneering Engipaedics—Space Age Technology Applied to Chronic Disease—Vernon L. Nickel, M.D., Chief, Surgical Services, Ranchos Los Amigos Hospital, Downey, California.

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M. E. ALBERTS, M.D., Scientific Editor

# NEW REPORTER FOR FAMILY PHYSICIANS

The American Academy of Family Physicians has launched a new publication to inform its members of major happenings in family medicine. The AAFP REPORTER will be a monthly news and feature bulletin and will carry no advertising. It will be presented in a 24-page, 4-column, 8½ x 11" format. The more than 35,000 members of the AAFP should find their REPORTER most helpful in keeping up with the programs and activities affecting them.

The editorial introduction in the first edition states that the publication goal will be to report the news of the rapidly growing and changing field of family practice as quickly as possible in an easy to assimilate format. That mission seems well within grasp based on an examination of the first issue. Headlines announce major happenings, e.g., millions of dollars for family practice residency programs; 35,000 physicians are now members of the AAFP; concern regarding PSRO; the AAFP role in a hypertension program, and reports on the recent AMA clinical session.

We wish this new publication a long and healthy life. The family practitioner is and shall remain the backbone of American medicine.—M.E.A.

# CATARACT "ROTO-EXTRACTOR"

Occasionally a press release will pique a personal interest which is unrelated or only indirectly related to the primary message of the release. Such was the case with a recent report from the American Academy of Ophthalmology and Otolaryngology. The report tells of a unique drill-like instrument used in the removal of difficult eye cataracts. The high speed device resembling a dental drill promises to restore sight to people blinded by difficult to remove cataracts which may have resulted from a blow to the eye. These cataracts may be old and tough.

The instrument basically consists of a small high speed electric motor housed in a handpiece

which drives a needle-shaped knife at a speed of 1,200 revolutions per minute. The hollow knife is inserted into the cataract. Water may be pushed through the lumen of the needle to wash away cataract "sawdust" and suck it out. The instrument has been used successfully in 98 patients

I do not dismiss this technique as unimportant but must admit that it was not the report of this "Roto-extractor" itself that caught my eye (no pun intended). It was the name of its developer—an ophthalmologist known to many in Iowa inasmuch as he spent some years of residency training at the University of Iowa Hospitals—Dr. Nicholas G. Douvas, now of Port Huron, Michigan. Besides that, I knew Nick before that when we were students at the same high school in Hastings, Nebraska.—M.E.A.

# RANDOM THOUGHTS AT AN AIRPORT

All of us at one time or another have had to spend some time waiting for a plane, or train, or whatever. Sometimes in such a situation there is nothing to do but watch people. People are interesting, and deserve to be studied. After all, this is our life work—to know the human being and how he functions. Yet, have you ever just sat and watched people in a public arena and wonder what their life is all about?

Recently I had to wait several hours for an airline connection in New Orleans—or was it at the new Dallas-Fort Worth Airport? No matter, it was a large busy air terminal and there were hundreds of people milling about or busy with their individual jobs. I made a few random notes of thoughts I had about some of the kindred souls at that busy airport—my thoughts about their thoughts and actions.

Walking is a peculiar and complex muscular action. Man is unique in his ability to walk in an upright position with his forelimbs hanging free or holding onto something or someone. Each person walks in an individual manner. Some shuffle, others lean slightly forward and walk rapidly; some drag a foot (injured? lazy?). Some of the people at the airport were running—late for a plane, hurrying to meet someone—hurry, hurry—passing another walking very slowly as though not caring whether he advances.

A clerk in a gift shop next caught my eye. She was a good subject to study. No, she wasn't a beautiful girl—probably married and trying to help the family budget. Business was slow. Was she thinking about what to cook for the evening meal—or her child at the baby-sitter's home—or wondering if she would ever fly to some exotic vacation resort? What was she thinking of the

# FAMILY PRACTICE PROGRESS

A survey of 1974 graduating medical students by the American Academy of Family Physicians shows (1) more medical students than ever are choosing family practice, and (2) the demand for first-year spaces in family practice residencies travelers stopping by her shop, most of whom were just looking? Was she envious, or thinking "those poor slobs"? Why do people purchase gifts at airports—promised? guilt feelings? something from grandmother to grandson? Only the purchaser knows—or does he?

The clothes people wear are another subject and everything seems "in" with travelers. There are mix-and-match ensembles, and many mix-and mis-match outfits. The casual dress mixes with the high fashion—an older, dapper, mustached gentleman in dark slacks and white jacket, carrying a cane and elongated cigarette holder—young and old attempting to maintain their balance in ridiculous platform shoes—clean clothes, well-tailored and pressed—dirty jeans and sweat shirts—a panorama of "fashion."

So it went—on and on. Finally my plane was announced and it was my turn to get up, walk across the terminal, and perhaps be watched by another person. The same panorama of humanity continues today and tomorrow. All around us is the drama of life. Perhaps if we stop to watch and listen we will be able to understand our fellowman better. They have purpose in life (we hope). They have been somewhere and are going elsewhere. They love; they become aggravated; they laugh and cry; they have elation, and fears and sadness. Life is great, isn't it?—M.E.A.

exceeds the number of spaces available by almost two to one.

It is estimated that approved family practice residency training programs will reach the 230 mark by January 1, 1975. The current training units report 2,014 graduates seeking first-year spaces.





by HAROLD MOESSNER, M.D.

Dr. Moessner is chairman of the IMS Committee on Medical Education and Hospitals. His comments here relate to that committee's important involvement in continuing medical education.

Continuing medical education is a key topic under consideration by the Committee on Medical Education and Hospitals. What is the current status of your deliberations?

The General Assembly passed a resolution in 1973 which says "that each examining board be required to submit in writing to the General Assembly no later than January 14, 1974, its recommendations for continuing education requirements for licensed or registered members of its occupation or profession." Dr. Howard Ellis is a member of our IMS committee and the Board of Medical Examiners. He advised of the Board's desire to maintain close contact with the IMS on this subject. Several joint meetings have occurred and a report for the 65th GA has been prepared. These six points summarize the report:

- 1) Iowa physicians are currently devoting an extraordinary amount of time, effort and money in the pursuit of professional education.
- 2) If legislation is enacted to require continuing education as a prerequisite for licensure renewal among the professions and occupations in Iowa, no groups should be exempted.
- 3) Any legislation should be permissive and grant authority to the Board of Medical Examiners to establish continuing education requirements by rule and regulation.
- 4) A 150-hour minimum requirement should be established for continuing education over a three-year period with credit being allowed for a variety of experiences.
- 5) The Board should have authority to waive continuing education requirements for physicians under certain circumstances.
  - 6) The CME requirements should be applicable

to Iowa license holders residing both in and outside the State.

# Have your conferences with the Board of Medical Examiners been productive?

The meetings with the Board have been most beneficial. I have been pleasantly surprised by the nearly uniform opinions on continuing medical education which have been expressed.

# How would you characterize continuing medical education in Iowa? Compared to elsewhere?

The amount of continuing medical education undertaken by Iowa physicians is tremendous. Unfortunately, many do not document their efforts. A recent study by Richard M. Caplan, M.D., and Thomas Yarcheski of the University of Iowa College of Medicine showed the average Iowa physician (in a sampling of 150) devotes approximately 350 hours per year to some kind of CME. I believe this would compare favorably with any other part of the country.

# Would you make any predictions as to what the future holds for Iowa physicians in this area?

It is interesting that the survey of Iowa physicians mentioned before showed that 71% of the physicians sampled believe some form of continuing medical education will be required in the near future. I certainly agree with this position. The difference of opinion seems to be over what organization should document the evidence of CME. At present three states (New Mexico, Maryland and Kansas) tie evidence of CME to relicensure. Oregon has CME requirements for membership in its state medical society. The American Academy of Family Physicians and the American Osteopathic Association also have CME requirements as a condition of membership. I believe the next few years will provide an answer to the question of which method Iowa will use.

# State Department of Health

# COUNTY BOARDS OF HEALTH

In January 1972 we reported in this section on the improvement in local public health programs in Iowa. However, we indicated much more progress was still needed. Much improvement has been made since then, but as before much remains to be done.

Passage of the Local Health Act (Chapter 163, Acts of the 62nd General Assembly) in June 1967 provided the basis for upgrading local public health activities. This act requires each county board of supervisors to appoint a five-member county board of health to include at least one physician. In addition, cities over 25,000 population were given the option of continuing a city board of health, and a mechanism was provided for creation of local health districts by combination of two or more county boards of health or city and county boards. The powers of the local boards include:

- (1) Enforcement of state laws and regulations.
- (2) Passage of local rules and regulations, following public hearing, publication, and approval of board of supervisors or city council.
- (3) Cooperation with cities and towns in the enforcement of city ordinances.
  - (4) Employment of necessary personnel.
- (5) Provision of personal and environmental services (primarily public health nursing and sanitary inspection).
- (6) Cooperative program development with other agencies.
- (7) Charging of fees to those who can afford to pay for personal services (this makes participation of nurses in the Medicare program possible, if other conditions are met).
- (8) Issuance of licenses or permits in specified program areas.

The January 1972 article reported on a survey of county boards of health that was done in August 1971. We have recently completed a new survey of county and city boards of health. A comparison of the two surveys indicates some of the progress that has been made in the two years. Below are listed some of the highlights of that comparison.

August 1971		November 197
58	Number of county boards of health indicating they meet reg- ularly	83
82 of 99	Number of boards employing one or more public health nurses	85
21	Number of boards employing one or more full or part-time environ- mental health workers	40
	Number of Boards with:	
23	Official rules and regulations	51
21	Residential Sewage	38
10	Private Water	21
9	Food Service	9
4	Housing	7
5	Public Health Nuisance Control	33

As shown above more county boards of health are meeting regularly. By meeting on a scheduled basis the boards develop an ability to plan ahead rather than simply react to problems that have already developed. In public health nursing the survey shows a small increase in coverage from 1971 to 1973. A comparison with 1965, when only 45 of the 99 counties had public health nursing services, is much more dramatic. Of the few remaining counties without public health nursing services, several are now working on the development of such service. Many counties with only one full-time public health nurse have expanded to provide an additional full or part-time nurse. This activity has increased the amount of overall service to the physicians and residents of the county.

The number of counties that employ a full or part-time environmental health worker and the number of counties that have adopted official rules and regulations regarding various environmental problems has approximately doubled. This indicates the great interest of local boards of health in preventing or correcting environmental problems.

According to the survey, there are now 416 full-time and 121 part-time employees of the county boards of health, city boards of health or visiting nurse associations. A calculation of per capita expenditures for each county for calendar year 1972 is presented below. These figures represent all expenditures from the local health fund of the county board of health, plus expenditures of the city boards of health and visiting nurse associations in the counties where they exist. The results indicate a wide range of per capita expenditures in the various counties. As would be expected, the counties with the higher expenditures have the more active and extensive programs.

Per Capita Expen	diture	Number of Counties
\$ .0049		17
.5099		14
1.00-1.49		21
1.50-1.99		21
2.00-2.99		16
3.00-3.99		7
4.00-4.99		2
over 5 00		1

Most county boards of health utilize a mixture of funds to support their programs. Some basic support is provided through local tax funds. Over half the boards may have some federal funds through the Iowa State Department of Health, ing funds for support of their public health program. As has been the case since the Local Health Act was passed in 1967, county boards of health still suffer from a lack of available funding. The local tax funds for public health still must come from the county general fund. In most of the counties the general fund is already levied to its limit and no additional funds could be made available for needed public health services. There are proposals, House File 72 and Senate File 250, to provide for local tax funds outside the general fund in support of local public health services. There is also a proposal to provide a state appropriation to be used for the support of local boards of health. Such support is critically needed if county boards of health are to continue to develop the services the residents of the counties need and deserve. The Iowa State Department of Health and the people of Iowa appreciate the efforts of the many physicians and the other citizens who serve on the county boards of health. We can see the benefits of this work in the improved and expanded programs of the county boards of health. We believe most Iowa physicians also recognize these benefits. The general public is also becoming more aware of the services. We hope the General Assembly will recognize the great work being

either on a special project basis or on the basis

of a shared salary project for the public health

nursing service. Most boards also have some fee income from their public health nursing program

and/or environmental program. Eleven county

boards of health reported they were receiving or

have been promised general federal revenue shar-

# EPIDEMIOLOGY TRAINING FOR LOCAL HEALTH DEPARTMENT EMPLOYEES

The Infectious Disease Division and the Education and Training Committee of the Iowa State Department of Health has initiated a program to provide local health department personnel an opportunity to participate in the semi-annual "Prin-

ciples of Epidemiology" training course at the Center for Disease Control in Atlanta, Georgia. The Scott County, Linn County, Black Hawk County, Sioux City-Woodbury County, Dubuque City, and Ottumwa City Health Departments have each had an employee who is actively involved in disease investigation and control programs take the CDC course. The training enables health personnel to become more proficient in this activity and to better serve their community.

done and provide the appropriate support.

# Morbidity Report for January, 1974

Disease	Jan. 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties	Disease	Jan. 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties
Adenovirus	6	6		Johnson, Polk	Meningococcal				
Ascaris &					meningitis	1	- 1	3	Howard
hookworm	- 1	I		Polk	Meningitis, type				
Chickenpox	733	733	1949	Scattered	unspecified	4	4		Black Hawk, Howard,
Conjunctivitis	27	27	53	Scattered					Keokuk, Scott
Coxsackie B <sub>3</sub>	I	1		Jefferson	Meningitis,				
Cytomegalovirus					aseptic assoc.				
infection	12	12		Des Moines, Johnson,	with ECHO 4	- 1	- 1		Johnson
				Muscatine	Meningitis,				
Eaton's agent					bacterial due t	ło			
infection	7	7		Johnson, Polk, Story,	Hemophilus in	f. I	0.1		Polk
				Warren	Mumps	295	295	449	Crawford, Dubuque,
Encephalitis, type	9				•				Jones, Polk
unspecified	1	1		Ida	Pediculosis	33	33	17	Lee, Linn, Scott, Wapell
Enteropathogenic					Pertussis	ī	T.		Clinton
E. Coli		1		Tama	Pinworms	17	17		Polk
Erythema	•				Pneumonia	93	93	149	Scattered
infectiosum	24	24		Cherokee, Marshall, Polk, Warren	Rabies in anima	s 8	8	24	Buena Vista, Floyd, Muscatine, Story
Gastrointestinal					Rheumatic fever	5	5	2	Appanoose, Carroll,
viral inf.	720	720	1397	Audubon, Benton,	······································	•	•	_	Dubuque, Scott
71. di 1111.				Johnson, Lee, O'Brien	Ringworm, body	35	35	10	Pottawattamie
Giardiasis	2	2		Iowa, Louisa	Ringworm, scalp	2	2		Black Hawk, Pocahontas
Guillain-Barre	-	-			Rubella	2	2	39	Sac, Van Buren
syndrome	1	1		Tama	Rubeola	2	2	53	Mitchell, Pottawattamie
Hepatitis,	•			rama		17	17		Scattered
infectious	42	42	20	Linn, Marion, Muscatine	Salmonellosis			14	
Hepatitis, serum	6	6	3	Carroll, Dubuque, Polk,	Scabies	5	5		Cerro Gordo, Linn,
riepatitis, setuiti	U	·	,	Woodbury					Muscatine
Herpes simplex	8	8		Iowa, Jasper, Johnson, Linn, Worth	Shigellosis	11	11	39	Dubuque, Johnson, Scot Warren
Herpes zoster	7	7		Delaware, Iowa, Jefferson, Johnson	Streptococcal infections	923	923	505	Jackson, Johnson, Polk,
Impetigo	17	17	30	Cedar, Iowa, Linn, Louisa, Palo Alto	Tuberculosis,				Ringgold
Infectious				200130, 1 010 7 110	active	10	10	10	Scattered
mononucleosis	92	92	59	Johnson, Polk, Woodbury	Venereal disease	s:			
	42	72	37	Johnson, Fork, Woodbury	Syphilis	53	53	20	Scattered
Influenza-like	1888	1888	1213	Linn, Mitchell,	Gonorrhea	536	536	463	Scattered
illness									

# TODAY'S HEALTH ON TV

A new television series titled "Today's Health" has been announced recently by the American Medical Association and Standard Brands, Inc. The syndicated weekly half-hour series is designed to explore varied aspects of health and

medicine. Material from the AMA magazine, TODAY'S HEALTH, will be utilized; AMA experts and editors will act as consultants.

The program is being distributed beginning in April. It is hoped that from 60 to 100 TV stations will provide the program to an estimated audience of seven million.



Maynard Reece

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by TENORA MEYER, CMA

# CAN AAMA HELP YOU?

Almost every professon, religion, educational pursuit, charitable cause and recreational activity has an organization available to eligible people. Through such cooperative effort much more can be accomplished in broadening knowledge than by individual effort alone. The American Association of Medical Assistants (AAMA) has education as its primary objective. AAMA offers employed medical personnel, whether secretaries, receptionists, nurses, nurse aides or technicians, a program of continuing education while on the job.

A physician cannot spare time to train office personnel with his busy and demanding schedule. Yet, he needs some criteria to select office personnel. The certification program for medical assistants offers the physician a basis for identifying qualified prospective employees. He may be assured the Certified Medical Assistant (CMA), administrative or clinical, is qualified and has fulfilled the training requirements for employment in a physician's office. A further step has been taken this past year with the development of CMA specialty examinations, the first being offered in Pediatrics.

The AAMA is organized on a tri-level. There are six active chapters in Iowa—Cedar Rapids, Davenport, Des Moines, Mason City, Waterloo and Sioux City. These chapters form the Iowa Association of Medical Assistants and all state chapters comprise the national organization—the American Association of Medical Assistants with offices at One East Wacker Drive, Suite 1510, Chicago, Illinois.

In their monthly meetings on the local level, medical assistants meet to discuss common prob-

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

lems. An educational topic is presented by a qualified individual. Seminars are provided on the state level and national conventions occur every year in a different area of the country with outstanding programs presented by health leaders. Some chapters have organized study clubs.

The AAMA provides "The Professional Medical Assistant," a 30-35 page publication which contains educational articles on all aspects of medical assisting. New techniques and developments in medical care are presented as are new ideas on credit and business procedures.

We believe physicians benefit significantly by having their employees as members of AAMA and should urge them to consider membership.

Robert B. Hunter, M.D., Special Liaison from AMA Board of Trustees to AAMA Physician Advisory Board, said this in an article in "The Professional Medical Assistant": "So when a prospective member asks, 'What's in it for me?,' you might answer that 'you've already received a lot out of it, and what's more, you owe us.' Because the truth is that without the support of medical assistants who care as much about their profession as they do about their own careers—they will soon find that they have no profession. The educational programs which allow a person to become a qualified medical assistant exist mainly because thousands of people in America were willing to work unselfishly to set and maintain proper standards."

The standards and requirements of medical personnel are becoming higher each year. More health care details are being delegated to medical assistants to free physicians of time-consuming tasks so they can devote more of their time and knowledge to increased productivity in patient care.

We have been fortunate to have the support of the AMA and strive to maintain the ideals and goals which have been set forth.

# EAVESDROPPING ON THE DOCTOR AND HIS PATIENT

Act One, Scene One: Dr. John Doe's office in Anytown, Iowa. Mr. Smith visits with the doctor after a checkup.

Mr. Smith: You a member of that Iowa Medical Society, Doc?

**Dr. Doe:** Why, yes, Smitty, I belong to our county medical society, the state society, the AMA, and one or two other professional groups.

Mr. Smith: Most Iowa doctors belong, huh?

**Dr. Doe:** Yes, I guess between 90 and 95 per cent of the physicians are members. Why are you interested?

**Mr. Smith:** Oh, I don't know, I just see the name once in awhile, in the paper and all. I guess most of these associations and societies are just interested in getting more dollars for their members?

**Dr. Doe:** That's probably what a lot of folks think, Smitty. And I suppose there's some degree of validity in this conception. The Society is trying to protect my rights to practice, my rights to treat you as an individual in a personal and confidential manner. And, obviously, regardless of occupation, we all want a fair compensation for the services we render. So, the Society does devote effort towards these goals.

Mr. Smith: How do the doctors who belong to the Society really feel about some of the health care programs we've got and some of these national health insurance ideas we hear about?

**Dr. Doe:** Physicians probably hold more strongly to their individual opinions than most occupational groups. There are some who are dead set against any governmental or outside encroachment on their practices. Others see third-party or outside influence as less of an ominous phenomenon, so long as the profession by and large has the say, as it should, about the way patients are cared for.

Mr. Smith: Where do you stand, Doc?

Dr. Doe: I'm somewhere in the middle, like most. As you can see from the waiting room, I am so darn busy, my time is so heavily committed that I don't get myself as well informed as I should on these topics. Therefore, I feel I must put my trust and support with those physicians we have elected as officers. We have physician delegates from this county who serve in the Society's House of Delegates and they try to find that position on the major issues which is accept-

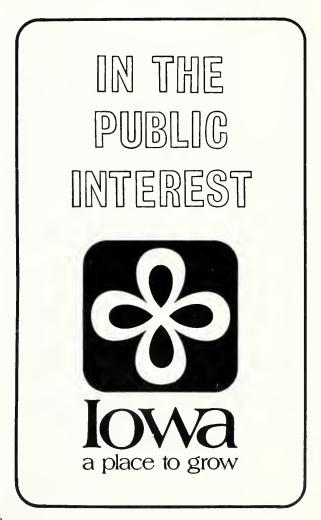
able to the majority. It's a hard job but, as they say, it's the democratic way.

**Mr. Smith:** So, what else does the Society do for you and for me that's of any consequence?

**Dr. Doe:** Well, that's a hard question to answer quickly. The Society has about four broad areas of activity: medical education, medical service, medical legislation and public relations. We try to be as effective as possible in these areas, both in your interest and in mine.

**Mr. Smith:** How about an example or two?

**Dr. Doe:** Okay, continuing medical education is a timely topic, there's a lot of talk about making it mandatory for doctors to record their educational activity. A survey made last year showed Iowa physicians spend about 350 hours a year in some form of learning. This is pretty good per-



formance. There's a move nationally to require documentation of continuing education and it is being spurred by the Iowa General Assembly. According to the survey, most Iowa doctors feel continuing medical education is soon going to be required in some fashion.

Mr. Smith: Does the Society have specific programs to get you and others informed about new developments?

Dr. Doe: Yes. The 1974 Scientific Program of the Society will cover three days in April and will be at the University of Iowa College of Medicine. I hope to attend most of it. The program includes numerous sessions with medical faculty members, we'll have a chance to visit with the professors in the various departments, even share specific cases which may be causing us some concern. Just to give you an idea, there'll be sessions on care of burns, problems of breast cancer, how to manage respiratory failure, and so forth. There are many scientific meetings available to us and this looks like a good one.

**Mr. Smith:** Are you involved in education programs for other than just doctors?

Dr. Doe: I know of several just around the corner. And probably many Society members aren't even aware of them. For example, the Society's Committee on Sports Medicine is putting on a Conference on the Medical Aspects of Sports April 4 at the Des Moines YMCA. This is for coaches, phys. ed. teachers, trainers and doctors who take care of kids involved in sports. A Dr. Fred Allman from Atlanta, Georgia, is the keynote speaker. I guess he's been in the sports medicine field for many years. This conference will last all day and is a joint venture with the Iowa High School Athletic Association.

**Mr.** Smith: Anything you do involve kids wanting to be doctors, nurses, and so on?

**Dr. Doe:** There's the Hawkeye Science Fair, that's been going on for 15 years. It comes up on April 5 and 6 at the Veterans Auditorium in Des Moines. Last year a record number of 700 junior high and senior high students had their scientific exhibits on display. They compete for various awards including some fine college scholarships. We are real pleased that several of the top win-

ners at the Hawkeye Science Fair have gone on to become physicians.

Mr. Smith: Kids are important. We need to do all we can to get them on the right track.

**Dr. Doe:** Right, Smitty. The Society helps sponsor the Iowa Youthpower Program which stimulates youth interest in good nutrition; it's also been a sponsor of and encourages youth participation in the Northwest Iowa School on Chemical Substances and Other Addictions; it's also been a supporter of the essay writing competition conducted by the Governor's Committee on Employment of the Handicapped. These'll give you an idea of different ways in which the Society spends some of its time and money.

Mr. Smith: Say, Doc, I'd better get out of here so you can get at those people who are waiting. I appreciate the information.

**Dr. Doe:** My pleasure. I guess most folks have an affinity for and a good relationship with their family doctor. But it seems people are often critical of the medical profession when it's considered in total, and some criticism may be justified. In broad terms, though, I think the efforts and programs of organized medicine are pretty positive in nature. . . . Take care of yourself, Smitty.

A CT ONE, Scene Two: The dinner table at the Smith residence.

Mrs. Smith: How did your checkup go today, honey?

Smitty: Everything turned out okay. Say, I got to talking with Doc Doe about the organizations he belongs to. You know we were talking the other day about the Iowa Medical Society, something in the paper about how they oppose a governmental idea to have some kind of prior approval before a person could be admitted to the hospital by his doctor, well, he gave a little run down on some of what his medical organizations do. Actually, they are into a lot of worthwhile things. It's too bad more people don't know about their activities. I guess that's true about a lot of groups and organizations.

The cast is small. The plot is not sharply defined and lacks explosiveness. But the message is a worthy one. Curtain going up!



Dr. Richard M. Caplan, professor of dermatology and assistant dean for continuing medical education at U. of I. College of Medicine, was a program participant at recent annual meeting of American Academy of Dermatology. Dr. Caplan discussed "Focusing Audio-Visual Aids for Medical Students, Non-Dermatologists and Allied Health Personnel." He participated further in sessions on undergraduate teaching programs and peer review. . . . Dr. Paul E. Orcutt, Marion, has been elected president of medical staff at St. Luke's Hospital in Cedar Rapids. Officers serving with Dr. Orcutt are the following Cedar Rapids physicians—Dr. J. H. Lolmes, president-elect; Dr. Walter Block, vice-president; and Dr. Percy G. Harris, secretary-treasurer.

Dr. William B. Bean, professor of internal medicine at the U. of I. College of Medicine, has had a new conference room named in his honor. Dr. Bean headed the Department of Internal Medicine from 1948 to 1970. The William B. Bean Conference Room is located on the third floor of the hospital's new southeast addition. . . Dr. R. L. Bendixen, Denison, was the guest speaker at recent meeting of Denison Rotary Club. Dr. Bendixen's topic "To and From Apollo 16." . . . Drs. Robert W. Barnes, Donald B. Doty, and Richard E. Kerber, all from Iowa City, have been named Fellows in the American College of Cardiology. . . . Dr. Juergen Holl has been reelected president of Clinton's Mercy Hospital medical staff. Other Clinton physicians elected were—Dr. L. Gregorio Lauz, vice president; and Dr. Salvador Borja, secretary-treasurer. . . . Dr. Donald D. Heistad, associate professor in internal medicine at U. of I. College of Medicine, has received \$1,000 award for a research paper presented in Toronto, Canada, at the Annual Scientific Assembly of the American College of Chest

Physicians. The Cecile Lehman Research Award was presented to Dr. Heistad for a paper entitled, "Interaction of Baroreceptor and Chemoreceptor Reflexes."

Dr. R. L. Bendixen, Denison, has been named chief of staff at Crawford County Memorial Hospital, Dr. Mark Tan Creti, Denison, is vice president; and Dr. M. U. Broers, Schleswig, secretarytreasurer. . . . Dr. E. E. Moore, radiologist at Trinity West Hospital in Fort Dodge, retired from active practice January 1. Dr. Moore received the M.D. degree at U. of I. College of Medicine; interned at Hurley Hospital, Flint, Michigan; had a radiology residency at Buffalo, New York and U. of I. Hospital. He is a past president of Webster County Medical Society; diplomate of American Board of Radiology, and has held all offices on the medical staff at Trinity West Hospital. . . . At medical staff meeting of Waukon Veterans Memorial Hospital, Dr. Alden Wiley was named chief of staff; Dr. K. Y. Lee, vice chief; and Dr. B. R. Withers, secretary. . . . Dr. Edwin C. O'Connor, New Hampton, retired from active medical practice in November. Dr. O'Connor had practiced in Chickasaw County since 1932 and joined Medical Associates in New Hampton in 1941.

Dr. Richard E. Vermillion, D.O., Ogden, is new president of Boone County Medical Society. Other officers include Dr. R. A. Manderscheid. Boone, vice president; Dr. J. F. Murphy, Boone, secretary-treasurer. . . . Dr. John W. Hughes. Marshalltown, was guest speaker at recent annual meeting of Marshalltown Community Hospital Auxiliary. . . . Dr. Donald J. Soll, Denison, is new member of Board of Directors of North Central Alcoholism Research Foundation. . . . Dr. Lee Marvin, formerly of Roanoke, Virginia, joined Dr. Ivan E. Brown, Hartley, at Hartley

Medical Center in February. Dr. Marvin received M.D. degree at U. of I. College of Medicine.

Dr. James H. Thomas, Sibley, recently received a certificate for humanitarian service from American Medical Association. Dr. Thomas spent 10 days in Immokalee, Florida, earlier this year with "Project USA," an AMA program coordinated with National Health Service Corps (NHSC) to send physicians to rural and urban areas facing critical medical personnel shortages. Project physicians substitute for NHSC personnel on leave from their assignments. . . . Dr. Irving J. Hanssmann, Council Bluffs physician for 22 years, retired from active practice in February. Dr. Hanssmann is a past president of Pottawattamie County Medical Society, Mercy Hospital staff, Pottawattamie County Tuberculosis and Health Association and Iowa Trudeau Society.

**Dr. Mark D. Pabst** is new president of the Davis County Hospital staff. Other 1974 officers are: Dr. James R. Mincks, vice president; and Dr. Michael B. Croxdale, secretary-treasurer. All are Bloomfield physicians. . . . Dr. Curtis W. Johnson has joined the Bluff Medical Center in Clinton. Dr. Johnson received the M.D. degree at the University of Illinois College of Medicine. He served his internship; a one-year residency in internal medicine; plus his residency and six-month fellowship in ophthalmology at University of Tennessee.... Dr. John W. Eckstein, dean of U. of I. College of Medicine, has been elected president of the Central Society for Clinical Research. Dr. Eckstein has been a CSCR member since 1957 and served as secretary-treasurer from 1965 to 1970. . . . Dr. James D. Mahoney, Council Bluffs, is director and physician consultant for Total Awareness, Inc., an anti-drug abuse agency providing counseling to drug users or potential users. Dr. Mahoney is chief of staff for the psychiatric unit at Mercy Northeast in Council Bluffs.

Dr Fred Colby has joined the staff of the Muscatine Community Health Center. Dr. Colby received the M.D. degree at University of Illinois College of Medicine in 1963. He completed two years of postgraduate training at Illinois Masonic Hospital and has practiced in Geneseo, Illinois, since 1965. . . . At January meeting of St. Joseph Mercy Hospital medical staff in Mason City, Dr. William G. Rence was elected chief of staff;

Dr. W. C. Rosenfeld, vice president; Dr. Samuel D. Porter, secretary-treasurer; and Dr. R. L. Borman, member-at-large. All are Mason City physicians. . . . Dr. Ramon A. Yaldua, Forest City, is a new Fellow of the American Society of Abdominal Surgeons. Dr. Yaldua, a general and plastic surgeon, and his wife, Dr. Christina Crespo-Yaldua, a gynecologist and obstetrician, do general practice in addition to specialty work at the Yaldua Clinic in Forest City. . . . Dr. Philip W. Caster has been named president of Davis County Medical Society; Dr. H. J. Gilfillan, vice president; Dr. John R. Scheibe, secretary-treasurer; Dr. Henry M. Perry, delegate; and Dr. Caster, alternate delegate. All are Bloomfield physicians.

Dr. Mohammed Doja, who formerly practiced in Centerville and Osceola, began a practice of general medicine and surgery in Chariton in January. Dr. Doja was associated with the Clarke Medical Clinic in Osceola and with Dr. S. S. Jewett and Dr. M. C. Parks in Centerville. . . . The following Council Bluffs physicians are new officers of Pottawattamie-Mills County Medical Society—Dr. Robert E. Joranson, president; Dr. Edward Farrage, president-elect; Dr. Krishna Birusingh, vice president; and Dr. Dallas Minchin, secretary-treasurer. . . . At recent meeting of Henry County Memorial Hospital medical staff, Dr. Ernest Lerner, Mt. Pleasant, was named chief of staff and Dr. Bill Nordyke, Winfield, secretary. . . . Dr. David E. Brandt, Waterloo, was guest speaker at recent meeting of Black Hawk County Chapter, American Association of Medical Assistants. His topic: "Eye Diseases and Problems."

The following Dubuque physicians are now officers of Dubuque County Medical Society—Dr. Richard H. Lee, Dubuque, president; Dr. John W. Moberly, vice president; Dr. Donald L. Kahle, secretary; and Dr. Ross A. Madden, treasurer. . . . Donald L. Taylor, executive vice president of Iowa Medical Society, was elected second vice-president of Professional Convention Management Association at the organization's recent annual meeting in Dallas, Texas. Mr. Taylor has been on the PCMA board for three years. . . . Dr. H. L. Brenton is new president of Cerro Gordo County Medical Society. Other new officers include Dr. W. V. Wulfekuhler, vice president; Dr. J. H. Brinkman, secretary; and Dr.

Vol. LXIV, No. 3

W. K. Dankle, treasurer. Dr. David F. Gordon, Des Moines, has been elected to fellowship in the American College of Cardiology and also to the American Heart Association's Council on Clinical Cardiology.

Dr. T. E. Shea, Storm Lake, was a recent guest speaker at Buena Vista College. Dr. Shea discussed medicinal chemicals used in anesthesia.

# **DEATHS**

Dr. Ralph T. Paige, 79, LaPorte City physician for 53 years, died December 17, 1973, at St. Francis Hospital. A graduate of U. of I. College of Medicine, Dr. Paige served as public health officer and assistant county medical examiner for many years. He was a life member of the Black Hawk County Medical Society, American Academy of General Practice, Iowa Medical Society and American Medical Association.

Dr. Richard R. Todd, son of Dr. and Mrs. Donald W. Todd, Guthrie Center, died December 14 at St. Francis Hospital in Tulsa, Oklahoma, of injuries suffered in an automobile accident in Claremore, Oklahoma. Dr. Todd was a staff doctor at U. S. Public Health Service Hospital in Claremore. He received the M.D. degree at the U. of I. College of Medicine in 1972 and interned at Valley Medical Center in Fresno, California.

# INDEX TO ADVERTISERS

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some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

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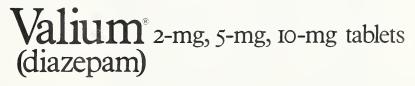
Precautions: If combined with r psychotropics or anticonvuls, consider carefully pharmagy of agents employed; drugs as phenothiazines, narcotics, piturates, MAO inhibitors and r antidepressants may potentiate action. Usual precautions cated in patients severely desed, or with latent depression, ith suicidal tendencies. Observed precautions in impaired renal

or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred

vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.





# President's Page

Accuracy and efficiency are two slippery characters in the third-party claims-handling melodrama of our times. We cheer loudly when this pair performs to our expectation; we jeer with gusto when they go awry.

Our heroes, accuracy and efficiency, seem baffled by different coding and nomenclature systems. Variety in this regard frustrates the administrative process, we are told.

In a frontal attack on this vexing problem, the Iowa Medical Society is advocating strongly that all Iowa physicians become familiar with and use the new American Medical Association/Current Procedural Terminology (AMA/CPT). The AMA/CPT lists medical terms and identifies codes in reporting medical services and procedures done



by physicians. Many physicians are already following the CPT in completing claims.

The Society is urging the Blues, the commercial insurance companies, government, etc., to adopt the AMA/CPT. We know such a conversion will take time and cost money. But we think the benefits to all will be worth the investment.

In cooperation with Blue Shield and the AMA, the Society has arranged for member physicians to receive an AMA/CPT. This is part of an educational program on the use of this important reference volume.

Sincerely,

Rubin Flocks, M. D.

Rubin Flocks, President

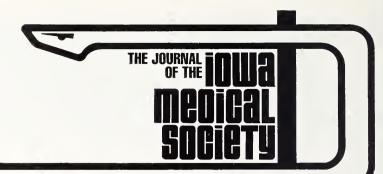
P.S. Please be reminded of the IMS Scientific Session in Iowa City April 18, 19 and 20.

# give her a present

Being a successful professional person means that ou are also a very busy person. Chances are you naven't enough time to manage your finances with horoughness and careful attention to detail. Further, he chances are, unless you already have a financial nanager, your wife is handling the chore. Now, eally, is it fair to expect her to perform a function hat takes years of training and experience to learn? Give her a vacation from your financial problems. She's earned it. Bring your investments and financial problems to your lowa bank. We have the skill and raining to make it pay off for you, and an Investment Management Account or Living Trust will spare you both a lot of bothersome details. It'll be like giving our wife her very own accountant, investment counsellor and a vacation all tied up in one package. And our fee is deductible. You win no matter how you look at it. See us soon. Iowa Trust Departments can save you time and money. And can save your

bank trust departments





VOL. 64 No. 4 APRIL, 1974

TABLE OF CONTENTS		Preventive Medicine and Environmental	150
Statement From John W. Eckstein, M.D., Dean, U. of I. College of Medicine Reports From U. of I. College of Medicine Departments Anatomy—Terence H. Williams, Ph.D., M.D. Anesthesia—Jack Moyers, M.D. Biochemistry—Carl S. Vestling, Ph.D. Dermatology—Robert G. Carney, M.D. Family Practice—Robert E. Rakel, M.D. Internal Medicine—James A. Clifton, M.D. Microbiology—J. R. Porter, Ph.D. Neurology—Adolph L. Sahs, M.D. Obstetrics and Gynecology—William C. Keettel, M.D.	139 140 140 141 141 142 142 143 143	Health—Peter Isacson, M.D. Psychiatry—George Winokur, M.D. Surgery—Sidney E. Ziffren, M.D. Urology—Rubin H. Flocks, M.D. Statewide Medical Education System for Training Resident Physicians in Family Practice—Paul M. Seebohm, M.D. Survey of Continuing Medical Education in Iowa—Richard M. Caplan, M.D., and Thomas Yarcheski, B.A.  EDITORIALS Annual University Issue On Roses & Prescribing  SPECIAL DEPARTMENTS	153 153 154 154 155 159 170 170
Ophthalmology—Frederick C. Blodi, M.D. Orthopaedic Surgery—Reginald R. Cooper, M.D. Otolaryngology and Maxillofacial Surgery—Brian F. McCabe, M.D. Pathology—George D. Penick, M.D. Pediatrics—Fred G. Smith, M.D. Pharmacology—John P. Long, Ph.D. Physical Therapy—Gary L. Smidt, Ph.D. Physiology and Biophysics—F. P. J. Diecke, Sc.D.	149 149 150 150 151 152 152 152	President's Page Iowa Medical Miscellany In the Public Interest State Department of Health Medical Assistants  MISCELLANEOUS The College Thanks Iowa Preceptors Acknowledge Service of Iowa Physicians	136 158 171 173 179 167 168

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Postmaster, send form 3579 to the above address.

CAL SOCIETY accords special recognition to The University of Iowa College of Medicine by designating April the University Issue. The tribute is doubly appropriate in 1974 inasmuch as on April 18, 19 and 20 the Iowa Medical Society Scientific Session will occur in Iowa City. This event exemplifies the excellent cooperative spirit which persists between the College of Medicine and the practicing physicians in Iowa.

John W. Eckstein, M.D., Dean, College of Medicine, introduces with brief comments here a series of short reports by the heads of the various departments which comprise the College. Following these are several worthwhile articles which advise of several activities which have impact for all Iowa physicians. The emerging statewide training program for family physicians is reviewed. And the Iowa physician survey on continuing medical education is summarized.



# UNIVERSITY ISSUE

JOHN W. ECKSTEIN, M.D. Dean, College of Medicine

# TO: MEMBERS, IOWA MEDICAL SOCIETY

### Dear Colleagues:

I am pleased for the opportunity to report once again on behalf of the College of Medicine. We believe the Annual University Edition of the JOURNAL is an appropriate and important complement to our other contacts with you—including professional interactions regarding patients, continuing education activities, and our many cooperative efforts on issues affecting both medical practice and medical education.

The bench marks of our mutual dependency and support relationship are clear for all to see. For our part, we are proud to have had a significant role in training at least every-other-one of you; we are your largest single provider in the education of your health manpower co-workers; some two-thirds of you annually participate with us in continuing education activities; we assist you in doing your best for your patients by providing you the consultative and tertiary care services your patients require; and we strive to provide new knowledge through the research that is necessary to assure the gradual and steady improvement in medical care.

You, in turn, provide us with patient referrals and service on collegiate committees; you stimulate our faculty to ever improve our patient care and teaching; and you participate directly in teaching our students through the MECO program, preceptorships, and clinical clerkships. You represent our interests with your patients and others in your community; their and your state and federal taxes provide us with three-fourths of our operating funds. We cherish your good will and the health of our relationship with

you, and we hope that this relationship may be further strengthened through your membership in the new Medical Center Constituent Society of The University of Iowa Alumni Association.

As a complex institution with diverse components, it is appropriate that our department

heads have the opportunity to tell you directly of progress and developments in their areas. Be assured that they would be pleased to hear from you if you have any comments or suggestions.—John W. Eckstein, M.D., Dean, College of Medicine

# **ANATOMY**

TERENCE H. WILLIAMS, Ph.D., M.D. Professor and Head

The first purpose of anatomy, over and beyond its undoubted general and historic interest, is to serve medicine now and in the future. The Department of Anatomy is embarking on an intensive reorganization program to involve all three major activities through which it serves medicine: (1) human anatomy instruction for health-care professionals; (2) graduate and post-doctoral training, and (3) research involving biostructure.

Through teaching workshops and major course revisions, a massive effort is being made (1) to prepare programmed texts and projection slide programs, and (2) to teach teachers to use these with wisdom and understanding of the subject. Teaching teamwork is being developed to enhance learning efficiency. Residents have been stimulated to teach and learn in the improved program, and an increasing number of physicians have indicated a desire to participate next year. The demand and need for a modern illustrated anatomy museum have been great, and we will

devote increasing efforts to prepare exhibits which should be of value and interest to practitioners

Job opportunities, primarily in medical schools remain good for Ph.D.'s in anatomy. Reorganiza tion and expansion of the anatomy Ph.D. pro gram is under way, and the outstanding medica students are also being offered opportunities for research which can lead to the M.S. degree. This research and postdoctoral training is concentrated on (but not restricted to) four themes that correspond to major faculty interests (see be low).

Research is directed at (a) cell biology with oncology, (b) endocrinology, (c) neurobiology and (d) reproduction. In addition, active re search is continuing in teratology and hematology. This specialization fosters intellectual excite ment and rewards, and makes good use of expensive modern instrumentation.

Physicians are asked to support the depart ment's expanded teaching commitments by en couraging interested patients to deed their bodies for medical science and education. Deed forms for our Gifted Body Program can be obtained by patients or physicians by writing the Department of Anatomy at the University of Iowa.

# **ANESTHESIA**

JACK MOYERS, M.D. Professor and Head

A number of activities in the Department of Anesthesia seem to me either to be of uncommon interest or to hold promise of unusual benefit to Iowa's practitioners. Some are new, some are old.

Of special significance and worth is Dr. Roland Kennedy's program in obstetrical anesthesia, now reaching maturity at a rapid rate. We are doing a much better job of identifying, treating and studying fetal distress, and of evaluating and managing the high risk mother, fetus and newborn. Residents and students knowledgeably discuss acid-base problems in both mother and baby

and are technically skilled enough to obtain and analyze blood samples from each. I believe the obstetrical team is more comfortable than ever before when faced with the problems of prema turity, infection, dehydration, blood loss, etc Promising research programs are a part of this improved effort in anesthesia for obstetrics, and the equally important field of perinatology.

Drs. Boutros and Hoyt added significantly to our capabilities in the Intensive Care Unit. They have used computerized data to afford "instant' cardiac output measurements and to study other measurable parameters. Further information has been gained from studies of treatment of poi soned individuals, a group in whom uncommonly good results have been obtained in the unit. All of us benefit, directly or indirectly, from ongoing research in such areas as renal effects of anesthesia (Dr. Bastron); neuromuscular response to depressant agents (Drs. Gergis and Sokoll); drug interaction (Dr. Ghoneim); and use of common sedatives in audiometry (Dr. Hosick).

All these activities find our students and house

# **BIOCHEMISTRY**

CARL S. VESTLING, Ph.D. Professor and Head

The Department of Biochemistry is a basic science department in the College of Medicine with broad responsibilities to other Colleges (Dentistry, Pharmacy, Liberal Arts and Graduate). We are fortunate to occupy a new laboratory with excellent facilities both for teaching and investigation. We interact both with colleagues in various basic disciplines in the University and with colleagues in the various clinical sciences. This latter relationship is a rich one in that highly productive interactions are taking place with our faculty and various research groups in the clinical departments of the College of Medicine.

The effort of our department is directed toward effective teaching and research for the principal reason that knowledge in the basic biomedical sciences is continuing to increase at such a rapid rate that one must continually strive to understand and present new concepts encompassing the whole subject. It is not always understood what a rapid fluid situation we are in with respect to new knowledge. It is not possible to teach effectively from old texts or old lecture notes.

We have specific interactions between members of our department and the clinical areas of investigation. For example, Professor R. L. Blakley, of our department, is doing fundamental

# DERMATOLOGY

ROBERT G. CARNEY, M.D. Professor and Head

The Department of Dermatology at the University of Iowa has become perhaps the foremost center in the country in dermatologic surgery.

staff (future Iowa practitioners!!) as first hand participants or informed observers. Moreover, our continuing education activities bring to returning practitioners the lessons we have derived from our daily work. In this way we hope what we are learning and doing will come to the attention of Iowa's physicians for the betterment of the patients they serve so well.

studies of the actions of various cancer drugs (anti-folates), and his studies are of great interest to clinical cancer groups in the College.

Dr. Roger Chalkley, of our department, and Dr. Daryl Granner, of the Department of Internal Medicine, have developed a close cooperation in studies of biochemical genetic changes which accompany different stages of cell division. Such studies are of obvious importance in attacks on the general problem of growth and differentiation and cancer. These studies also involve cell culture techniques which are highly developed. Other members of our department are also involved in cell culture experiments.

Dr. Arthur Spector, of our faculty, is vigorously pursuing studies in the lipid areas and is collaborating with Dr. William Connor from the Department of Internal Medicine in studies of various lipidoses, which relate to atherosclerosis and other allied subjects.

The Department of Biochemistry participates in several joint appointments where unusually close interactions have developed. The participating departments now include psychiatry, internal medicine, orthopaedic surgery and pediatrics. These joint affiliation appointments involve collaborative teaching and research.

In concluding this brief statement on the Department of Biochemistry and its relationship to its parent College of Medicine, the comment should be made that every effort to interact effectively continues with the certainty that benefits flow in both directions.

Procedures not only include electrosurgery of various skin tumors, but dermabrasion for scarring, precancers and tattoos, and hair transplants for male pattern baldness and scarring of hairy parts of the body. Another tremendous advance is in the use of sublesional and intralesional Triamcinolone for chronic dermatoses, keloids and a variety of other conditions.

# FAMILY PRACTICE

ROBERT E. RAKEL, M.D. Professor and Head

The year 1973 has witnessed a significant expansion of the Department of Family Practice and much increased activity in both undergraduate and graduate education. Our faculty has increased from five to 14 members, and the allied health personnel participating in medical student and resident training now number 11—covering pharmacology, nutrition, social work, laboratory analysis, problem-oriented record systems, nursing and research.

Our statewide network of affiliated University programs has grown to include four functioning residencies; and the number of family practice residents in training in the State affiliation has increased from 19 in fiscal year 1972-73 to 32 this year. The active affiliated family practice residency programs now exist at University/Mercy Hospitals in Iowa City, St. Joseph Mercy Hospi

# INTERNAL MEDICINE

JAMES A. CLIFTON, M.D. Professor and Head

The year, just past, has seen the initiation or further development of several major areas within the Department of Internal Medicine. These either are or will be having major impact on health care in Iowa. It is not possible to detail the entire list here, but a few programs may be cited to show the quality and thrust of the group.

Under the heading of *Improved Patient Care* three certainly stand forth. Firstly, the Division of Hematology has developed a team of experts, and the most modern facilities to care for individuals requiring intense cancer chemotherapy. Patients may now be sheltered from life-threatening infections in one of two Laminar Flow rooms and receive large volumes of matched granulocytes and platelets prepared by specialized cell separators. Secondly, three separate newly equipped cardiac catheterization laboratories provide critical information to the clinicians of the State. Computers instantly process volumes

tal in Mason City, and at Broadlawns and Iowa Lutheran Hospitals in Des Moines. The appropriation of \$925,000 from the Iowa General Assembly has facilitated the expansion program; and the inception of new programs in Davenport and Sioux City is anticipated during 1974.

Our undergraduate activities with approximately 700 medical students continue to expand, exposing them to the principles and concepts of continuing comprehensive family health care, and encouraging their choice of a residency position within the State's affiliated network. Student interest in family practice has increased considerably; and the department becomes increasingly involved with the Freshman Medical Education/Community Orientation (MECO) Program; the sophomore courses, Introduction to Family and Community Medicine and Introduction to Clinical Medicine; Junior and Senior level preceptorships; and some 16 senior electives offered by the Department of Family Practice.

We look forward to an even more productive and expansive role in the College's activities next year.

of data and allow the team to more precisely identify the abnormalities. Thirdly, the remarkable union and vigor of our Divisions of Nephrology and Allergy-Immunology, the Departments of Surgery and Urology and many physicians throughout the State to provide a network of chronic and satellite dialysis centers, home dialysis support and organ procurement represents a fine and comprehensive program.

undergone substantial Training has also change, and four programs have, or are being designed, to extend the experience in internal medicine beyond the confines of the University-VA Medical Center. These include rotations at the Broadlawns and Iowa Methodist Hospitals in Des Moines, at the new University Clinic in Muscatine, and with internists throughout the State arranged in cooperation with the Iowa Society of Internal Medicine. In addition to the obvious training value in providing primary patient care, each program allows the young physician to experience the qualities of non-University living and medicine in Iowa.

We have been pleased with the accomplishments of the year and anticipate they will continue to improve and flourish in the future.

# MICROBIOLOGY

J. R. PORTER, Ph.D. Professor and Head

The faculty in the Department of Microbiology is actively engaged in teaching and research, but has no patient service responsibilities.

Each year over 1,000 students from seven colleges are taught courses in general and pathogenic microbiology, immunology, microbial genetics, microbial physiology, medical mycology and virology.

Several highly significant research projects are underway in the department; a few examples will be mentioned briefly to indicate the breadth and diversity of the research.

Sporulation in bacteria is the simplest form of cellular differentiation known, and Professor Stahly and students are studying the mechanism that regulates this process.

The so-called BCG vaccine is currently being used in many parts of the world to immunize against tuberculosis. But the vaccine presents certain problems, i.e., not being too efficient and inducing delayed hypersensitivity which later eliminates a major diagnostic test for the disease. Professor Johnson is isolating stable ribosomal RNA fractions from the tubercle bacillus that may induce lasting immunity but not interfere with diagnostic testing.

The importance of controlling the immune response in both infections and degenerative diseases, as well as after transplantations, is well-known. The secondary immune response that results from an animal or human being encountering an antigen for a second time is now referred to as immunologic memory. Little is known

about this phenomenon, so Professor Feldbush is doing research on the subject. An understanding of the mechanisms involved could lead to better therapeutic approaches in certain diseases.

Interferon is a protein inhibitory substance produced by cells when infected with viruses. Professor Rodriguez was one of the first persons to do research on interferon. He is now studying the role of interferon in the course of, and recovery from, respiratory viral infections.

Research on human cytomegalovirus (CMV) is underway by Professor Stinski to determine the host cell constraints to virus replication and why the virus remains latent and potentially infectious in the host. Latent CMV may be transmitted by saliva or by blood transfusions to a recipient who then develops a disease resembling infectious mononucleosis.

Professors Butler and Crouch have demonstrated a particular antigen on epithelial cell neoplasms from human beings, and they have found corresponding antibodies in the sera of patients with such neoplasms. The particular antigen shares determinants with a bovine mucoprotein that is a normal constituent of bovine epithelial cell membranes. The relationship of the antigenic determinants is being studied with the thought of developing a test of value in the diagnosis of cancer.

The role of complement in antigen antibody complexes is being studied by Professor Hoffman, especially significant is why such reactions may lead to inflammation and tissue destruction.

Researches on filamentous fungal infections in experimental animals, and the characterization of certain enzymes isolated from pathogenic yeast, are being carried on by Professor Cazin. The results will be of great value in understanding fungal infections in human beings.

# **NEUROLOGY**

ADOLPH L. SAHS, M.D. Professor and Head

This issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY provides an opportunity to publicize some developments in the Department of Neurology which might be of assistance to Iowa physicians.

Since I have been directly involved in the activities of the Joint Committee for Stroke Facilities in Washington, I should indicate that we have completed a series of publications in the journal STROKE, which cover all phases of stroke prevention, diagnosis and care. This series represents the considered judgment of approximately 200 specialists in the field. Reprints of the various sections can now be obtained by writing to:

Joint Committee for Stroke Facilities Suite 1010 1776 K. St. N. W. Washington, D. C. 20006 We are in the process of collecting all the material developed by the committees to publish in monograph form under the heading, "Management of the Stroke Patient."

At the local level, we have recently inaugurated, with the collaboration of the Office of Continuing Medical Education, a departmental stroke program for interested physicians in the State. These are scheduled periodically under Dr. John Butzer. Groups of 10 to 12 physicians are now coming in regularly for intensive discussion of stroke problems.

Drs. Nibbelink, Perret, Graf and I are continuing to accumulate data on intracranial aneurysms and acute subarachnoid hemorrhage as part of a world-wide cooperative study. We will soon publish a report dealing with what we feel is the most effective supportive care during the first two weeks after the bleeding episode.

The development of reliable methods for the

determination of Dilantin, Mysoline and phenobarbital levels in the serum, using the gas-liquid chromatographic technique, has given us an entirely new perspective on the value of obtaining serum levels in the management of epileptic patients. Drs. Fincham and Schottelius have been responsible for the application of this technique locally. We hope this test can be modified and made more readily available to the entire profession in the State.

The development of the neuromuscular laboratory under the direction of Dr. Jun Kimura provides us with a much better understanding of neuromuscular disorders than before. It is now possible to obtain laboratory confirmation of such knotty problems as the carpal tunnel syndrome, myasthenia gravis and muscular dystrophy, particularly when they present atypically.

Space limitations will not permit the description of activities of our other staff members. They join me in conveying our best wishes.

# OBSTETRICS AND GYNECOLOGY

WILLIAM C. KEETTEL, M.D.
Professor and Head

The Department of Obstetrics and Gynecology participates in the teaching program in selected areas during the first year of medical school, and also in the second year's Introduction to Clinical Medicine. The major undergraduate teaching is in the third year when a six-week clerkship is equally divided between obstetrics and gynecology with emphasis on core material.

The major experience on gynecology is in the out-patient clinic, as well as in the operating room, with resident and senior staff participation. In-patient experience is provided primarily during the rotation on obstetrics when the junior student participates actively in the labor-delivery suite and enters into the team management of both antepartum and postpartum patients. During the fourth year, elective clerkships are offered in advanced obstetrics, advanced gynecology, endocrinology and oncology. Regrettably, the number of deliveries has decreased from nearly 2,800 in 1970 to only slightly over 2,000 in 1973. It is hoped the number of deliveries will

not decrease further; to do so would greatly compromise our undergraduate and residency training programs. We are grateful for the past and current support provided our Department by Iowa physicians in referring patients, this is invaluable to our program.

Our residency program is active not only in Iowa City but also with the senior resident rotation in Des Moines. It is gratifying that many residents who have recently completed our program have remained in Iowa and surrounding states. In fact, during the last 10 years, 15 of our residents have located in Iowa with another seven practicing in adjacent states.

Within the department, we have active divisions of gynecological oncology and endocrinology, and we are in the process of developing a perinatal unit staffed by an obstetrician-gynecologist, a neonatologist and an obstetrical anesthesiologist. It will serve as a model unit for physicians and nurses in Iowa.

Our out-patient clinics are designed to meet the needs of our varied selection of patients. Currently, these clinics include those for colposcopy, oncology, endocrinology, high-risk obstetrics, early termination of pregnancy and family planning.

# OPHTHALMOLOGY

FREDERICK C. BLODI, M.D. Professor and Head

Of great diagnostic importance to the Department of Ophthalmology has been the establishment of an ultrasound laboratory. Ocular echography enables us to examine the fundus even though the media are opaque. This method has proven to be a most valuable and important diagnostic tool for intraocular and orbital tumors. It is also used for the detection of foreign bodies and the diagnosis of retinal detachments when the fundus cannot be seen.

The department has now had some experience with the ultrasound fragmentation of cataracts.

# ORTHOPAEDIC SURGERY

REGINALD R. COOPER, M.D. Professor and Chairman

The Orthopaedic Department continues to organize its staff and clinical services into general and special clinics. We have restructured our refer service and appointment scheduling system to provide better care for patients referred by Iowa practitioners and to provide better education.

Dr. John Albright, who recently joined our staff from Yale University, adds particular expertise in cervical spine problems, athletic injuries, total joint replacements and metabolic bone disease. All patients with muscoloskeletal trauma sent to University Hospitals now receive the attention of the Orthopaedic Department. Dr. Bruce Sprague, who joined us from the Campbell Clinic in Memphis, Tennessee, directs our trauma service. In addition, he helps Dr. Flatt with an active hand service which provides a variety of care to patients with rheumatoid arthritis, degenerative joint disease, and traumatic and congenital hand defects.

This is done with a small needle introduced into the anterior chamber and is of benefit in operating on cataracts in infants or young patients. Further experience is necessary to find out whether this method is also applicable for senile cataracts.

The department has acquired the vitreous infusion suction cutter. This instrument enables us to remove the cloudy or organized vitreous together with preretinal membranes. It is an extremely useful method to clear vitreous hemorrhages.

The argon laser continues to be used for the treatment of retinal holes and other pathologic changes in the retina or choroid. The department is engaged in a cooperative study of the National Eye Institute to evaluate the usefulness of this treatment method in diabetic retinopathy.

Our children's clinics, directed by Drs. Cooper, Ponseti, and Albright, accommodate an increasing number of multiply handicapped children with birth defects (cerebral palsy, myelomeningocele, clubfeet, congenital dislocation of the hip, scoliosis) and acquired disorders. The complex care of these children requires coordination with other departments and with the Hospital School. The prosthetic clinic on the second and fourth Wednesdays of each month attends to the needs of the amputee through the expertise of physicians, prosthetists, physical therapists and others. Dr. Bonfiglio directs a service for patients with musculoskeletal neoplasms and a service for patients with complications of fractures. Dr. Larson supervises our active Veterans Administration Hospital General Orthopaedic Service and a Disability Evaluation Center at Oakdale.

During the past year, new types of total joint replacements, especially for the hip and knee, have helped reduce the pain of patients with rheumatoid arthritis and degenerative joint disease.

# Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

April 5 April 18-20 April 23-24

May 6-9

Ophthalmalogy Clinical Canference lawa Medical Society, Annual Scientific Meeting Current Developments in Care of the High-Risk Obstetrical Patient and Newbarn

Cardialagy Taday

May 9 May 9-11 What's New in Stroke lawa Eye Assaciatian

lawa Canference an Agina

May 10-11 May 13-17

**Nuclear Medicine** 

May 16-18

Diagnastic Radialogy in Otolaryngalagy

# OTOLARYNGOLOGY AND MAXILLOFACIAL SURGERY

BRIAN F. McCABE, M.D. Professor and Head

The biggest change in the Department of Otolaryngology and Maxillofacial Surgery has been the establishment of a pleasant and modern new clinic of 7,000 sq. ft. to replace the old countyhospital image clinic. All patients are now processed as private patients, regardless of the type of registration. In the new outpatient area an ambulatory patient surgical unit has been established to reduce markedly the cost to patients of some of our operations, particularly cosmetic operations. In this way, many of our operations, not covered by insurance because of their cosmetic nature, can be provided to patients at a third or less of the cost were these patients taken to the regular operating rooms and housed as inpatients.

Electronystagmography for the study of the dizzy patient has been graduated from research status to the clinical area. This is an entirely new unit established for the study and diagnosis of

# **PATHOLOGY**

GEORGE D. PENICK, M.D. Professor and Head

The year 1974 is seeing many reorganizational efforts of the Department of Pathology begin to reach fruition. Geographic consolidation is becoming a reality. Newly constructed hematology and chemistry laboratories have replaced those previously existing on the other side of the hospital. Laboratory computerization is underway to bring to University Hospitals the most modern, automated laboratory systems that technology makes available. The transfusion service is developing much closer working relationships with community blood banks of Iowa in an effort to expand its services to patients from this region, especially as they relate to providing high quality blood and more readily available blood components.

A number of personnel changes have occurred and at least two new faculty members will join the department this summer: Dr. Pasquale A. Cancilla, currently vice-chairman of the Departdizziness, cervical vertigo, Meniere's disease and other conditions which tax all practitioners.

Our five senior residents (all Board qualified) have been placed on staff status to improve patient handling and cut waiting time. Many heretofore private patients, as designated by referring physicians, but not directed to one of the staff members, will be seen by these otolaryngologists and if their problem is not of a serious nature, they are much more rapidly diagnosed and managed than previously.

Finally, a Center for Congenital Malformations of the Head and Neck staffed by a number of experts, including general and regional plastic surgeons, is being established and is already functioning in nature if not in name. Patients can be referred directly to this center within the department for a multidisciplinary approach to their problem. The center will be happy to see all problems of the head and neck exclusive of the brain and the eye. These problems include not only cleft deformities but tumors, including lymphangioma and hemangioma, hypertrophies and atrophies, ear, nose, and other facial deformities, scalp, nose and orbital deformities, to give a partial listing.

ment of Pathology at UCLA and a recognized authority in neuropathology, and Dr. Fred R. Dick, a specialist in hematopathology and the son of Dr. Fred Dick of Waterloo. Others have indicated considerable interest in joining the department in the near future. Expansion of the staff has permitted the initiation of a number of new research efforts, especially in the areas of blood disorders and neoplasia.

Most encouraging of all are the number and quality of students and post-doctoral trainees now looking to the department for their training experiences. A total revamping of the formal courses for the medical students into a selfpaced, largely self-instructional pattern has made possible the development of special programs for interested students; seven externs and one graduate student are currently engaged in full-time pathology activities. A full complement of 20 interns and residents is anticipated by this summer, many of whom we hope will remain in Iowa as faculty or practitioners. Comprehensive programs in anatomic and clinical pathology are made possible by the now consolidated laboratory operations at University and V.A. Hospitals. The consolidation has also permitted the blending of the two previously separate training programs in medical technology. Simultaneously, the department has expanded its teaching activities to stu-

# **PEDIATRICS**

FRED G. SMITH, M.D. Professor and Chairman

In July, 1973, Dr. Fred G. Smith, Jr. was appointed the new chairman of the Department of Pediatrics. He was formerly Professor of Pediatrics and Chief of the Division of Nephrology at the UCLA School of Medicine. During the past six months, a number of other new faculty have been added to the department. They will provide much broader pediatric consultative service for the community and physicians throughout the state. The following new faculty have been appointed and are either presently active or will join the faculty in July, 1974.

**Dr. Robert Thompson** from Johns Hopkins College of Medicine—Pediatric Endocrinology

**Dr. Allen Erenberg** from UCLA School of Medicine—Neonatology

Dr. Richard Schieken from the University of

dents of dentistry, physical therapy, physician assistance and other allied health areas as part of its contribution to meeting Iowa's health care needs of the future.

Pennsylvania College of Medicine—Pediatric Cardiology

**Dr. Thomas Kisker** from the University of Cincinnati College of Medicine—Pediatric Hematology and Oncology

**Dr. Ekhard Ziegler** from the University of Innsbruck—Neonatology and Nutrition

**Dr. Jean Robillard** from the University of Montreal—Pediatric Nephrology

**Dr. Martin Myers** from the Children's Medical Center at Boston—Pediatric Infectious Disease

Dr. John MacQueen has been appointed as the new director of the pediatric ambulatory services and Dr. Mary Couchman will assist in this area as the associate director. The ambulatory program is being reorganized to provide more comprehensive pediatric consultative services for the physicians in Iowa.

The Department of Pediatrics is also planning an expansion of their pediatric postgraduate programs to provide more accessible educational programs in the area of pediatric health care.





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# PHARMACOLOGY

JOHN P. LONG, Ph.D. Professor and Head

The Department of Pharmacology has added faculty in the following areas: cardiovascular, neurological and toxicology. The increases in faculty have resulted in several increases in offerings. The department has expanded its teaching in clinical pharmacology and has added a course in clinical toxicology. The educational program of the department will take on an added

# PHYSICAL THERAPY

GARY L. SMIDT, Ph.D. Director

Integration of physical therapy activities (research, teaching and clinical service) is being developed along lines of each specialization area: musculo-skeletal, cardiovascular, respiratory, neurological and pediatrics. Therefore, this paradigm demands a team of professionals in which there must be depth in basic and clinical science rationale, capabilities for teaching, conducting and advising research, and participation with the team in problem-solving activities.

The physical therapy program at the University of Iowa is a professional program within the College of Liberal Arts. The basic two-year curriculum leads to certification in physical therapy, and was initiated in 1942. The M.A. degree program was instituted in 1948, and a new Ph.D. program in physical education, with specialization in physical therapy, was approved in 1972. Over 600 students have graduated from the basic

# PHYSIOLOGY AND BIOPHYSICS

F. P. J. DIECKE, Sc.D. Professor and Acting Head

The Department of Physiology and Biophysics has a faculty of 23 full-time members and joint appointees. We occupy spacious new quarters on the fifth and sixth floors of the new Basic Sciences Building, as well as space in the Neurobiology Division building on the Oakdale Campus. The department is involved in the profes-

dimension this semester in the offering through the extension division of a course entitled *Drugs*: *Their Nature*, *Action and Use*.

During the past year the department also created a new course in pharmacology for physicians' assistants, which was well received by the students. The department continues to offer a broad series of courses in our attempt to provide current, unbiased information on drugs to the health professionals, health scientists and laymen. With the ever expanding role of drugs and chemicals in our society all of us have this important responsibility.

program since its inception, and 52 have received the M.A. degree. There are currently 80 students enrolled in the basic program, five in the M.A. program, and five in the Ph.D. program. From the different levels of education physical therapy practitioners, clinical specialists, supervisors, and professors of physical therapy are emerging.

Faculty members and students in the physical therapy programs are heavily involved in fundamental and clinical research. During the last three years, 20 interdisciplinary projects have been undertaken with colleagues in the College of Medicine and Engineering.

The physical therapy clinic is located in Children's Hospital and is staffed with 10 therapists and a number of sub-professional personnel. Each therapist has specialized skills and knowledge which are applied to a particular category of clinical activity. Several therapists are directly involved with research projects, and a number of promising new evaluation and treatment techniques, developed within these projects, have been tested and used on clinic patients.

sional education of medical, dental, paramedical and undergraduate students. In addition, the department offers a graduate program to students interested in teaching-research and to medical students desiring joint M.D.-Ph.D. degrees.

The educational program for medical students has undergone significant change in recent years. Since the introduction of a new medical curriculum, the department has offered a medical physiology course consisting of cardiovascular, respiratory, renal and gastro-intestinal physiology to freshman students and has participated in an in-

tegrated neurobiology course for sophomore students. This course includes neuroanatomy, neurophysiology and behavior. In addition, graduate physiology courses are open to senior medical students as electives. Through lectures and small group discussions, these courses correlate basic physiological principles with pathophysiology.

The faculty members pursue extensive re-

search programs in basic and applied physiology and collaborate in interdisciplinary research with other departments. Current research interests include cardiovascular physiology, exercise physiology, renal physiology, respiratory physiology, biophysics of growth, biophysics of excitation and contraction, endocrinology, biomedical engineering, membrane transport and neurobiology.

# PREVENTIVE MEDICINE AND ENVIRONMENTAL HEALTH

PETER ISACSON, M.D. Professor and Head

Changes in the past year have been primarily in new program development and in the strengthening of existing programs. Directed by Dr. John Berg, who joined our faculty from the National Cancer Institute, a Cancer Epidemiology Research Program has been established and the Iowa Central Tumor Registry is being reinstituted. This will greatly strengthen our studies of environmental aspects of cancer etiology and is also specifically aimed at providing a service for Iowa hospitals.

Donald Morgan, M.D., Ph.D., has taken over direction of the Iowa Community Pesticides Program and will be concerned not only with mechanisms of pesticide toxicity but also the long term health effects on populations such as Iowa agri-

# **PSYCHIATRY**

GEORGE WINOKUR, M.D. Professor and Head

Significant changes have occurred recently within the department. On a clinical level the institution of a new admission policy and an effort directed toward rapid admissions and treatment programs and short-term care with clinic and community follow-up has enabled us to increase the number of patients seen at the Psychopathic Hospital by about 40%. Waiting lists are at a minimum and there are now between 700 and 800 admissions to the hospital per year. Similarly, the outpatient clinic has been reorganized and it is growing in size and service. Clinic efforts in child psychiatry have likewise been increased

cultural workers. The biostatistics section has two new members, and the amount of collaborative research and consultation with clinical departments has markedly increased.

Teaching opportunities have increased for both graduate and medical students, with the new elective fourth year medical curriculum providing an excellent opportunity for medical students with particular interest in community health to explore this area in greater detail. Main strengths of the department continue to reside in the areas of environmental health, epidemiology and biostatistics.

The unifying theme for teaching and research is the interest in looking at problems of health as they affect entire communities, and to look for measures to improve health which can be most usefully applied to persons in groups rather than on an individual basis. Our department is particularly interested in relating to Iowa practitioners who face such problems of community health. We are delighted to hear from local physicians.

and now new patients are seen four days a week. The inpatient child service has been revitalized and the stays of patients have been cut from  $5\frac{1}{2}$  months to about 70 days. Further, the department is running a day program for junior high students with learning and behavior problems in the community, a summer program for similar young people and a clinic for treating enuresis.

As regards faculty, a number of new people will be joining the staff in July. Thus, there will only be one budgeted position open by that time.

In the area of research over 70 scientific papers were published within the last year by members of the faculty. Some, as the use of lithium for the acute treatment of depression and the use of behavioral techniques in anorexia nervosa have considerable practical significance. Basic contributions to the neurochemistry of behavior and the electrophysiology of behavior have been

produced. A number of papers have been concerned with the practical management of personality disorders and other psychiatric problems.

The department has successfully competed for and obtained federal support for follow-up studies of the treatment of hyperactive children, for a large study of the epidemiology of schizophrenia and affective disorders, and for the neurophysiology and cytochemistry of the drugs of abuse.

# **SURGERY**

SIDNEY E. ZIFFREN, M.D. Professor and Head

In patients with metastatic cancer of the liver we continue to have improving results from ligation of the hepatic artery accompanied by insertion of a tiny catheter in the artery which is followed by continuous chemotherapy. The treatment of the obese patient by gastric bypass is proving very successful in these difficult patients and has received increasing recognition nationally. With the inauguration of our own esophagoscopy and gastroscopy unit we are better able to evaluate the sites of bleeding in the upper gastrointestinal tract, as well as sites of stricture and tumor. It has proved equally reliable in evaluating reflux esophagitis, for which surgical therapy is now quite successful.

In the treatment of severe burns we are finding that massive antibiotic therapy coupled with local therapy has reduced the mortality even more. Formerly we had used such antibiotic therapy only when a patient developed signs of infection. With immediate use, deaths from infection in severe burns is becoming even less common.

In the field of reconstructive and esthetic surgery we are advancing the use of subcutaneous mastectomy in severe fibrocystic disease or in-

# **UROLOGY**

RUBIN H. FLOCKS, M.D. Professor and Head

The most important activity occurring within the Department of Urology during 1973 was the opening of the Prostatic Disease Center with funds which have been donated specifically for this purpose to the Iowa Foundation. The ProsThe residency program is almost totally full. There have been changes within the medical student teaching program to orient it more toward the practical management of patients and to provide a good basis for students who will enter the fields of primary medical care.

In general then last year has been an exciting and productive one.

traductal hyperplasia. Following this procedure we insert a silastic prosthesis to maintain the breast contour. In this manner the patient retains the configuration of her bosom and eliminates the possibility of developing a breast malignancy.

The cardiac surgeons continue to do open heart procedures in large numbers with a very low mortality. Replacement of damaged valves is highly successful. Total intracardiac correction of infant cardiac anomalies is increasingly performed, as is coronary bypass for severe angina. In Peripheral Vascular Surgery new noninvasive technics of study enable the surgeon to better improve and evaluate operative results.

In neurosurgery stereoscopic angiography and air studies provide a three dimensional view not previously obtainable. Stereotaxic destruction of areas in the brain is available to correct dystonias, Parkinsonism and spasticity. Stereotaxic percutaneous cordotomy is also used for the treatment of intractable pain. The stereotaxic method is a very safe operation, especially in the poor risk patient.

The transplantation unit has performed more renal transplants than ever before, with even greater success. Conducted in association with the Departments of Urology and Internal Medicine, it is now on the verge of encompassing other organs.

tatic Disease Center has initiated several significant projects with regard to the management of prostatic cancer. Funds have been obtained from the National Cancer Institute, with four other national institutions, for collaborative study with regard to chemotherapeutic agents in the management of disseminated prostatic cancer.

Dr. David Lubaroff, a specialist in immunopathology, has been added to the staff to participate and initiate further controlled studies in the immunotherapy of prostatic cancer. This work has been accelerated as a result of observations in our department of the effects of cryosurgery upon disseminated prostatic cancer.

In addition, the educational activities of the

department have tremendously and excitingly undergone rapid development with funds for this purpose given primarily by the Flocks Fund in the Iowa Foundation and by Eaton Laboratories. These are being developed under the direct administration of Dr. David Culp.

# The Statewide Medical Education System For Training Resident Physicians In Family Practice

PAUL M. SEEBOHM, M.D. lowa City

Senate File 598 passed by the 65th General Assembly to establish a statewide medical education system to train resident physicians in family practice was implemented in July, 1973. Family practice training programs in the United States are less than five years old. It was not until February 8, 1969, when the standards for training and certification in family practice were approved by the Advisory Board of Medical Specialties, that substantial planning of educational programs was started. Since that date, however, continuous program development has occurred both nationally and in Iowa.

On March 25, 1969, the College of Medicine initiated a feasibility study for both undergraduate and graduate training programs in family practice.

In June, 1969, the 63rd General Assembly adopted Senate File 655 which authorized the University of Iowa to study the use of existing facilities in Polk County and elsewhere in the state for the training of students as general medical practitioners.

In January, 1970, the Board of Regents approved a unanimous recommendation of the fac-

ulty of the College of Medicine to establish a Department of Family Practice at the University of Iowa. In December, 1970, Robert E. Rakel, M.D., was appointed Professor and Head of the Department of Family Practice in the College of Medicine.

In a recent survey of the 110 medical colleges in the country, 49 were found to have family practice programs. Of these, 25 had created full departments but only five of the departments have been operational for four years or more. This places the University of Iowa among the first five colleges of medicine to establish a department of family practice.

In July, 1971, a major affiliation agreement was consummated between the College of Medicine and Broadlawns Hospital. In December, 1971, family practice residency programs at Broadlawns and St. Luke's-Mercy in Cedar Rapids were accredited by the AMA residency review committee for family practice, the first in the State of Iowa to be authorized to provide residency training in family practice. By July, 1972, three programs (Broadlawns in Des Moines, St. Luke's-Mercy in Cedar Rapids and the Family Practice Department in Iowa City) were accredited and had a small number of residents in training.

In the calendar year 1973, the family practice movement in Iowa has shown a significant surge in the rate of growth. This growth in most categories of measure has either kept pace or exceeded national trends.

Dr. Seebohm is associate dean of The University of Iowa College of Medicine. He is chairman of the Family Practice Education Advisory Board.

### UNDERGRADUATE EDUCATION IN FAMILY PRACTICE

Both the University of Iowa and the College of Osteopathic Medicine and Surgery have increased enrollments over the past several years, so it could be expected that student interest in the various specialties might increase proportionately. In actual fact, surveys of student interest at the University of Iowa College of Medicine show both a percentage and an absolute increase in interest in family practice.

The Medical Education-Community Orientation (MECO) program is an elective assignment offered by community hospitals and physicians to freshman medical students wishing a real-life medical experience early in their academic career. Interest in this program shown by both the communities and the students reached an all-time high in 1973.

### MECO PROGRAM

	1970	1971	1972	1973	Increase '73 over '72
Number of students	18	48	64	82	+28%
Number of hospitals		32	35	52	+48%

The sophomore course "Introduction to Family and Community Medicine" was elected by 29 students in 1972 and 35 students in 1973. The senior electives in family practice, the majority (75%) of which are community-based, were selected by 47 students in 1972 and 70 in 1973.

Along with the development of new opportunities for training in family practice has been a growing interest in this specialty among medical students. The biographical inventory of incoming students at the University of Iowa College of Medicine has shown an increasing interest in family practice as a career choice.

FRESHMAN MEDICAL STUDENT CAREER CHOICE
OF FAMILY PRACTICE

		1966	1967	1968	1969	1970	1971	1972	1973
Number of Percentage	students	33	28	44	32	52	71	87	85
of class		27	22	34	25	36	49	52	51

These data show an increased interest in family practice developing in 1970. This coincides with the clarification of the role of the family practitioner in the health care delivery system and the greater visibility given the specialty in

the medical college curricula and hospital residency programs.

### RESIDENCY TRAINING IN FAMILY PRACTICE

The increased interest of medical students in family practice as a career requires provision for an adequate number of residency training programs. One of the most misunderstood concepts in medical education is the depth of training required to develop a high quality professional for the practice of family medicine. The teaching of the tremendously expanded body of medical knowledge developed in the past two decades can no longer be compressed into the medical college curriculum and one year of a hospital internship, which was the standard of training for general practice 40 years ago. A recent College of Medicine evaluation of physicians under 50 years of age who left rural practice in Iowa indicated most returned to hospital residencies for further professional training.

The residency training requirements of family practice absorb the internship year into the first year of residency and require two additional years of residency training; that is, a total of three years after graduation from medical college.

The Statewide Medical Education System for training resident physicians in family practice, which was established effective July, 1973, by the 65th General Assembly with a biennial appropriation of \$925,000 is well underway. There are now five accredited training programs in the state:

Mercy Hospital, Iowa City
St. Luke's-Mercy Hospital, Cedar Rapids
Iowa Lutheran Hospital, Des Moines
Broadlawns, Des Moines
St. Joseph Mercy, Mason City

These have been developed on the following schedule:

# ACCREDITED RESIDENCY PROGRAMS IN FAMILY PRACTICE IN IOWA

	1969	1970	1971	1972	1973
Number	. 0	0	1	3	5

Additional programs are now under development in:

Davenport Sioux City Waterloo

lowa\*

U. S. A. . .

Coincident with the increase in the number of programs there has been a growth in the enrollment of residents in training, a trend projected to increase further with the filling of positions in existing programs and the opening of new programs. Through 1973 the growth of family practice residencies exceeded the national growth by several hundred per cent.

### FAMILY PRACTICE RESIDENTS IN TRAINING

 					Proie	cted	
70-71	71-72	72-73	73-74	74-75	•		77-78
 0	3	12	49	78	112	126	144
 165	632	1041	1680	_	_	_	_

<sup>\*</sup> Includes University of Iowa Residency Program.

The number of applicants for residency appointments has also increased substantially.

# NUMBER OF APPLICATIONS RECEIVED FOR FAMILY PRACTICE RESIDENCY POSITIONS

(Iowa City, Broadlawns, Cedar Rapids, Iowa Lutheran and St. Joseph Mercy)

1973-74	1974-75	
111	215	

### FAMILY PRACTICE ADVISORY BOARD

The 11-member Family Practice Advisory Board was constituted in the fall of 1973. Its membership, geographic distribution and terms of appointment are noted.

The Board, in cooperation with the administration of the College of Medicine, has surveyed hospitals and communities with residency programs in the planning or operational stage and recommended to the College of Medicine the previously noted on-going programs be budgeted and supported in 1973-74; and the new sites of Davenport, Sioux City and Waterloo be designated for the development of programs with support being budgeted in 1974-75.

The Board further advised that on-going program support be based on the number of full time equivalent residents in training in the program, and established for 1973-74 the capitation rate to be \$5,000 per resident enrollee. Developing programs with less than 5 residents were approved for base support after a full time director is acquired and accreditation established. The Board also budgeted funds for model office

construction or renovation for developing programs.

### THE FUTURE

Although the Statewide Education program authorizes supporting educational programs up to 50% of their total cost, the level of support provided by the appropriation does not permit more than meeting 22% of the total cost in the 1973-75 biennium.

In the next biennium Statewide Family Practice Residency Programs will grow in both the number of training sites and in resident enrollment. At the same time the community hospital fiscal status is likely to remain the same or become more restricted. The federal training support is unstable, but is likely to continue at its present level for another year or two. It therefore seems reasonable to project a budget that would set the State appropriation level closer to the authorized percentage of support, as well as an increment appropriate to the growth in number and enrollment of the training programs.

The results of the internship and residency matching program announced at this writing show that all of the Iowa Family Practice programs are filled for the year 1974-75. It is obvious there is a growing interest among medical students in family practice and therefore a need for an increased training capacity in this specialty.

The progress to date in the development of these programs would not have been possible without substantial support from the communities in which they are located. The physicians, generalists and specialists alike, have donated many hours of instruction for the resident trainees, principally by inviting them to participate in the care of their patients. Likewise hospital administrators and members of hospital boards have sponsored and financially supported the development of facilities and the major costs of education. The Statewide Educational System then continues to be a cooperative venture between the medical community, the College of Medicine, HEW, and the State of Iowa. The program is off to a successful start.

In July, 1974, seven family physicians will be graduating from the programs of the Statewide System. These will be the first physicians to have received the three years of formal training in Family Practice in Iowa. As the programs mature

(Please turn to page 158)



DATES... 1974 IMS Scientific Session is this month, April 18, 19, and 20, in Iowa City. Program appeared in the March JOURNAL and in a flyer sent to the full membership. Annual Meeting of IMS House of Delegates will be May 11, 12 and 13 in Des Moines. Full sessions of the House will occur the afternoon of May 11 and the morning of May 13. Hearings of Reference Committees will be the morning of May 12.

HANDBOOK MAILED . . . Society activities for 1973-74 are highlighted in the Delegates handbook mailed in late March to those IMS members who'll represent their county societies at the Annual Meeting.

FOUR RESOLUTIONS... From county societies appear in the 1974 Handbook. These resolutions from Des Moines-Louisa, Dickinson and Polk (2) counties were received prior to the Handbook deadline. Additional resolutions may be submitted for House consideration.

LIABILITY... Insurance matters were discussed March 21 by the Medico-Legal Committee with the State Insurance Commissioner, representa-

tives of the state's principal malpractice carrier and the Society's group insurance administrator. Significant premium hikes are a source of concern to the committee.

PROGRESS... In the implementation of the physician's assistant law was explored at a March 20 meeting stimulated by the IMS Board of Trustees. Participants included Board members, representatives of the Board of Medical Examiners and IMS Committee on Delivery of Health Services.

VISIT PENAL FACILITIES . . . Special IMS Committee on Health Care in Correctional Institutions gathered first-hand info on care provided at Iowa's four penal institutions in recent visitations. Reports on findings will be submitted to the House of Delegates.

VISIT CONGRESSMEN... IMS and IMPAC officers made annual trek to Washington, D. C., in mid-March to call on members of the Iowa congressional delegation. Discussion covered wage-price controls, pre-certification requirements, etc.

# FAMILY PRACTICE TRAINING— Dr. Seebohm

(Continued from page 157)

this number will reach about 50 family physicians a year, a number that should start to reverse the negative balance of physicians entering and leaving practice in Iowa.

# FAMILY PRACTICE EDUCATION ADVISORY BOARD MEMBERSHIP

Paul M. Seebohm, M.D., Chairman

Associate Dean, University of Iowa College of Medicine Iowa City

Robert E. Rakel, M.D.

Head, Department of Family Practice, University of Iowa College of Medicine, Iowa City Larry Lawhorne, M.D. (1974)

Family Practice Resident, University Hospitals, Iowa City

L. Robert Martin, M.D. (1975)

Program Director, Cedar Rapids

R. Keith Simpson, D.O. (1974)

College of Osteopathic Medicine and Surgery, Des Moines

Charles Ingersoll (1975)

Administrator, Des Moines

Ralph L. Wicks, M.D. (1976)

Iowa Medical Society, Boone

Kenneth L. Clayton, D.O. (1976)

Iowa Society of Osteopathic Physicians and Surgeons, Spirit Lake

Donald J. Ottilie, M.D. (1974)

Iowa Academy of Family Physicians, Oelwein

Mrs. Madge Phillips (1977)

Public Member, Cedar Rapids

Mrs. Claudine Mansfield (1977)

Public Member, Humboldt

# Survey of Continuing Medical Education in Iowa

RICHARD M. CAPLAN, M.D., and THOMAS YARCHESKI, B.A. Iowa City

The Iowa Medical Society's Committee on Medical Education and Hospitals and the Office of Continuing Medical Education at The University of Iowa College of Medicine surveyed a random sample of IMS members in March and April, 1973. Information was sought that would: (1) describe the population of IMS members by background variables such as age, size of community, number of associates in practice, etc.; (2) describe the nature and scope of their continuing medical education activities; (3) gauge their opinion on current issues in continuing medical education. Ultimately, this information will be used to plan more meaningful educational programs for practicing physicians.

A random sample of 150 from among 2,297 IMS members was selected via a computer-generated table of random numbers. The sample size of 150 insures statistically that a sample percentage will not differ from the true population percentage by more than 8 per cent, ninety-five percent of the time (i.e., using repeated samplings). Of this 150, 13 were found to be no longer engaged in full-time active practice and were therefore deleted. Physicians were guaranteed anonymity in completing the questionnaire. One hundred eight of the 137 distributed questionnaires

Dr. Caplan is assistant dean, Continuing Medical Education, The University of Iowa College of Medicine. Mr. Yarcheski is a research assistant in the Office of CME and is a doctoral student in hospital and health administration.

If broadly perceived, continuing education is being pursued to an impressive extent by lowa physicians. Also, of importance is the fact that 71% of lowa physicians anticipate a CME requirement in near future. These are among findings of a 1973 survey project undertaken by The University of Iowa College of Medicine Office of Continuing Education in cooperation with the Iowa Medical Society Committee on Medical Education and Hospitals.

were returned, giving a response rate of 79 per cent. This response rate insures that a sample percentage will not differ from the true population percentage by more than 9 per cent.

There is no reason to suspect the sample of 108 IMS members, which represents approximately 5 per cent of the total, is not representative. The specialty distribution within the sample compared favorably to the specialty distribution reported by Aschoff¹ about the total IMS membership, and the specialty distribution reported by Bale² about all physicians practicing in Iowa. Bale's data on the age distribution of Iowa physicians also compared favorably to our sample age distribution. It is also reasonable to extrapolate the results to the "physicians of Iowa," since 92 per cent of them are IMS members, and are distributed by specialty much as are the IMS members.

The questionnaire was also completed by 138 physicians who attended the Refresher Course for the Family Physician held in Iowa City during February, 1973. We will make occasional reference to this data. Although 97 per cent of the respondents in this group were family physicians and 72 per cent were practicing in Iowa, the "non-

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF APRIL, 1974.

TABLE I SIZE OF COMMUNITY

Population Pe	er Cent
Less than 1,999	9
2,000- 4,999	9
5,000- 9,999	8
10,000-19,999	6
20,000-49,999	27
50,000-99,999	18
More than 100,000	23
Total	100

randomness" of this sample dictates caution in generalizing about the total population of Iowa family physicians.

Responses to the questionnaire were organized into four major categories which will serve as the structure of this report:

- I. Basic Information
- II. Present Continuing Education Activities
- III. Obstacles to Continuing Medical Education
- IV. Planning

### I. BASIC INFORMATION

Information was collected for 13 background variables.

- 1. Sex: One hundred per cent of the respondents were male.
- 2. Age: The median age of our sample is approximately 50 years.
- 3. Type of Practice: Eighty-seven per cent of the surveyed physicians are engaged in private practice, with 7 per cent filling full-time hospital positions, 4 per cent filling academic positions, and 2 per cent filling other types of positions.
- 4. Size of Community: The data are presented in Table 1.
- 5. Number of Hospital Staff Appointments: Physicians in the sample each had approximately two hospital staff appointments (median). It is important that almost all IMS members have some degree of colleague contact via hospital staff membership, a condition importantly different from some large metropolitan centers elsewhere in the nation.
- 6. Approximate Average Hours Spent Per Working Day in a Hospital: IMS members spend a median of approximately four hours each working day in a hospital.

- 7. Approximate Average Hours Spent Per Working Day in the Office: The physicians surveyed spend an approximate median of six hours each day in the office.
- 8. Years Since Graduation from Medical School: The median length of time since graduation from medical school was approximately 25 years.
- 9. Medical School Attended: Fifty per cent of the physicians surveyed graduated from the University of Iowa. The second largest percentage among all other medical schools was only 6 per cent. Twelve physicians, or 71 per cent of the youngest physicians, age 30 to 39, graduated from the University of Iowa.
- 10. Area of Principal Medical Work: Family physicians accounted for 39 per cent of our sample compared to 41 per cent in Aschoff's data about all IMS members, and 45 per cent in Bale's data about the total population of Iowa physicians.<sup>2</sup>
- 11. Number of Associates in Practice: Thirtyfive per cent of the surveyed physicians practice in the solo mode, 20 per cent practice in partnerships, 13 per cent practice in groups of 3, 8 per cent practice in groups of 4, 3 per cent in groups of 5, and 21 per cent in groups of 6 or more. The solo mode of practice appears to be least appealing to younger physicians. Six per cent of the youngest physicians, age 30 to 39, were engaged in solo practice, compared with 43 per cent for the 40 to 49 age group, 34 per cent for the 50 to 59 age group, and 42 per cent for the 60-and-over age group. Fifty per cent of the physicians engaged principally in Family/General practice were solo practitioners, compared with 25 per cent for all other medical disciplines.
- 12. Highest Level of Formal Graduate Education: The median number of years of formal graduate education was approximately 3. The distribution was bi-modal: for 26 per cent the internship was the highest level completed, while 44 per cent completed the internship plus 3 or 4 years of residency.
- 13. Board Certification: Fifty-eight per cent of the respondents were board certified. This contrasts with the 32 per cent for all Iowa Physicians reported by Bale.<sup>2</sup> The respondents to our questionnaire thus were weighted toward those with board certification, a bias perhaps worth remembering in evaluating some of the subsequent data.

### II. PRESENT CONTINUING MEDICAL EDUCATION ACTIVITIES

This section is subdivided into three main categories: (1) Reading; (2) Audiovisual; and (3) Attendance-Participation.

All responses in this section were cross-tabulated with all responses in the first section in an attempt to pinpoint significant associations ("significant" in terms of the Chi-Square test when p < .05). Only those associations discovered to be significant are reported.

#### 1. Reading.

The physicians surveyed regularly receive a median of approximately five professional journals (this includes the Journal of the Iowa medical society, Jama, and any other journal publications received by virtue of membership in a professional organization). The number of professional journals regularly received was found to be associated with the principal area of medical work,

TABLE 2

NUMBER OF JOURNALS READ ALMOST TOTALLY,
READ IN-DEPTH, AND SCANNED

At Least 1 Complete						
	Read Almost Totally	Article Read In-Depth	Only Scan Titles and Summeries			
Journals	Per Cent	Per Cent	Per Cent			
None	19	3	15			
	10	11	10			
2	32	28	31			
3	. 20	21	12			
	. 10	10	10			
5	1 3	15	7			
6 or more	· , <u>6</u>	_12_	15			
Total	100	100	100			

i.e., family practitioners receive less than the average number of journals when compared to all other physicians combined. Table 2 summarizes physicians' journal-reading habits.

The two most popular forms of published materials read other than subscribed professional journals are textbooks and unsubscribed professional journals, respectively. When the physicians were asked about the frequency of their clipping, copying and note-taking habits, 31 per cent responded "often," 32 per cent responded "occasionally," and 37 per cent responded "seldom" or "almost never."

One of the most important items on the ques-

tionnaire concerned the amount of time devoted to professional reading. The responses shown in Table 3 indicate that physicians spend a median of approximately 4 hours each week reading professional material.

TABLE 3

APPROXIMATE AVERAGE NUMBER OF HOURS OF PROFESSIONAL READING PER WEEK

Hours	Pe	r Cent
None		0
Less than I		
I up to 2		
2 up to 4		38
4 up to 6		21
6 up to 8		
8 up to 10		8
More than 10		
Total		100

The number of hours spent each week in professional reading was found to be associated with the amount of time spent each day in the hospital and the years of formal graduate education. That is, physicians who spend more than the average number of hours each day in the hospital . . . and physicians who had four or more years of graduate education spend more than the average amount of time engaged in professional reading.

#### 2. Audiovisual Methods.

Table 4 summarizes physicians' use of audiotapes as a method of continuing medical education during the previous year.

TABLE 4
USE OF AUDIO-TAPES IN THE PREVIOUS YEAR

Frequency of Use	Per Cent
Regularly	19
Often	
Occasionally .	
Rarely	14
Never	
	100

We found four significant associations which characterize the physicians who used audio-tapes during the past year: (1) they are over age 40; (2) they had less than 4 years of formal graduate education; (3) they spend more than the average

TABLE 5
HOURS SPENT IN COLLEAGUE CONSULTATION ABOUT
PATIENT PROBLEMS IN THE LAST YEAR

Hours		Per Cent
Not used		
Less than	1	
l up to	5	5
5 up to	10	7
10 up to	20	16
20 up to	50	22
50 up to	100	18
More tha	n 100	30
Total .	• • • • • • • • • • • • • • • • • • • •	100

amount of time in their offices; and (4) they practice primarily in family/general practice.

Fifty per cent of the physicians who have used this method of continuing medical education in the past year listen to audio-tapes mainly while at home, 25 per cent listen to them mainly while traveling in their cars, and the remainder listen to them either in their offices or the hospital.

Generally, the physicians who use this method listen to audio-tapes for a median of approximately 45 minutes each week. The only variable which was found to be significantly associated with the amount of time spent listening to audio-tapes was the number of hours spent per working day in the office. Physicians who spend an average of six or more hours each working day in their offices spend more than the average amount of time listening to audio-tapes.

Two additional audiovisual methods of continuing medical education were covered by the questionnaire—television and radio-telephone conferences. Twenty-four per cent of the surveyed physicians have used television for continuing medical education during the past year, and 19 per cent have used radio-telephone conferences.

Twenty-three per cent of the surveyed physicians have used other audiovisual methods of continuing medical education during the past year which were not specifically investigated by the questionnaire. These other audiovisual methods include slides, photographs and films.

#### 3. Attendance-Participation Methods.

Several dimensions of this general category were measured by the questionnaire. These dimensions include colleague consultation, hospital conferences, post-graduate lectures, symposia, courses and other types of attendance-participation methods such as home study courses and self-assessment examinations.

A. Colleague Consultation. Generally, physicians spend a median of approximately 50 hours each year consulting colleagues about patient problems. The complete data are presented in Table 5.

Spending more than the average amount of time consulting with colleagues about patient problems was found to be significantly associated with: (1) spending more than the average amount of time each working day in the hospital; and (2) practicing principally in areas other than family/general practice. The latter association is supported by the data collected at the Refresher Course. The median for that group was approximately 30 hours a year.

B. Hospital Conferences. Eighty-seven per cent of the sampled physicians had attended at least one hospital conference (excluding staff business meetings) during the past year. The physicians who use this method of continuing medical education spend a median of approximately 17 hours a year attending hospital conferences.

C. Post-Graduate Lectures, Symposia, Courses, etc. The responses to this item were tallied according to the organization which sponsored the lecture, symposia, course or similar type of activity. Four organizations were identified in the questionnaire—medical schools, county medical societies, state medical societies and the American Medical Association. (Lectures, symposia and courses sponsored by specialty societies were, unfortunately, omitted from the questionnaire.)

Eighty-seven per cent of the surveyed physicians had attended at least one lecture, symposium, course or similar type of medical-school-sponsored activity during the past year. Overall, the median time spent engaged in these kinds of continuing medical education activities was approximately 30 hours per year. This median amount of time was found to be associated with a particular age group. Physicians under 40 years of age spend more than the average amount of time attending lectures, symposia, courses and similar activities sponsored by medical schools than physicians over 40.

Forty-five per cent of the surveyed physicians indicated they had attended a lecture, symposium, course or similar type of continuing medical education activity at the University of Iowa College of Medicine within the past year, and 65 per cent indicated they had attended within the past three years.

The numbers of physicians who have attended lectures, symposia and courses sponsored by county medical societies, state medical societies and the AMA during the past year are 74 per cent, 31 per cent and 5 per cent, respectively. The median number of hours spent by participating physicians who attended county medical society-sponsored CME activities is 7 hours per year; for state medical society-sponsored CME activities, approximately 5 hours per year; and for AMA sponsored activities, approximately 10 hours per year. The data are presented in Table 6.

D. Self-Assessment and Home Study Course Methods. Fifty per cent of the physicians surveyed indicated they have used other types of attendance-participation methods of continuing medical education during the past year. These methods include primarily self-assessment examinations and home study courses. The group of physicians that use these methods use them for a median average of approximately 20 hours per year.

Which method of continuing medical education is most effective? Table 7 summarizes the way physicians rated the effectiveness of each CME method identified in the questionnaire, plus the effectiveness of each organization sponsoring CME activities. The three methods receiving the greatest percentage of the "very effective" rating were: (1) continuing medical education activities sponsored by medical schools (70%); (2) colleague

TABLE 6

TIME SPENT ATTENDING CME ACTIVITIES SPONSORED
BY COUNTY MEDICAL SOCIETIES, STATE MEDICAL
SOCIETIES AND THE AMERICAN MEDICAL ASSOCIATION

Hours Per Year	County Per Cent	State Per Cent	AMA Per Cent	
Not used	26	69	95	
Less than I	3	3	1	
l up to 5	23	13	0	
5 up to 10	35	8	1	
10 up to 20	10	6	2	
20 or More	4	1	1	
Total	100	100	100	

consultation (57%) and (3) self-assessment and home study courses (50%). These three methods were ranked in the same order by the physicians attending the 1973 Refresher Course. The effectiveness ratings assigned to each method of continuing medical education were not significantly associated with any of the 13 background variables.

By adding the median values for times spent in the various kinds of learning experiences (including users and non-users) we find that the sampled physicians spend over six hours each week engaged in CME activities. Since the questionnaire unfortunately omitted the CME activities sponsored by the various specialty societies, we are inclined to believe that the true median is close to seven hours per week—almost a full working day.

TABLE 7

SUMMARY OF THE RELATIVE EFFECTIVENESS OF DIFFERENT CME METHODS AND ORGANIZATIONS SPONSORING CME ACTIVITIES (PERCENTAGES BASED ON THOSE OFFERING AN OPINION)

Opinion	Reading	Audio-Tapes	Television	Colleague Consultation	Radio/Television Conferences	Hospital Conferences	Medical Schools' CME Activities	County Medical Societies' CME Activities	State Medical Societies' CME Activities	AMA CME Activities	Self-Assessment Exams, Home Study Courses, Etc
Very effective	35	29	20	57	39	22	70	17	18	25	50
Moderately effective	38	29	50	29	22	41	23	40	32	19	43
Somewhat effective	27	37	17	12	28	32	5	25	30	31	7
Not effective	0	5	13	2	11	5	2	18	20	25	0
Total	100	100	100	100	100	100	100	100	100	100	100

TABLE 8

THE RELATIVE IMPORTANCE OF SIX DIFFERENT METHODS
OF CONTINUING MEDICAL EDUCATION

Method	• .	Ranking by Refresher Course Physicians
I. Individual study (read	•	
audio-journals, etc.)		2
<ol><li>Participation in course</li></ol>		
by medical schools		I
<ol><li>Participation in prog</li></ol>		
fered by regional	/national	
groups other than	medical	
schools	3	4
4. Participation in grou	p activi-	
ties with colleagues	such as	
consultations, hospita	l confer-	
ences, journal clubs,	etc 4	3
5. Participation in educ	ation-ori-	
ented study of prac	tice pat-	
terns in the local ho	spital or	
office, in order to a	determine	
needs by analyzing	care ac-	
tually rendered	5	5
6. Self-assessment tests	and pro-	
grams		6

#### III. OBSTACLES TO CONTINUING MEDICAL EDUCATION

Sixty-six per cent of the surveyed physicians indicated that their present cluster of methods for "keeping up" is either satisfactory or very satisfactory while 34 per cent responded that their present cluster of methods is either less than satisfactory or not satisfactory. For the Refresher Course physicians the percentages were 60 per cent and 40 per cent, respectively. The similarity of these responses in the two groups of physicians suggests that the level of dissatisfaction is not primarily a function of specialty status.

What are the most important obstacles to continuing medical education? The questionnaire identified 11 obstacles and the one which received the most responses, twice as many as the next most important obstacle, was "insufficient time due to patient care load." The second and third most important obstacles were: (2) insufficient time due to personal factors; and (3) content of programs not relevant to practice. The remaining obstacles, in the order of their importance, were: (4) too much time required getting to and from program sites; (5) programs contain insufficient usable information;

- (6) lack of available courses, programs, etc.;
- (7) programs and courses too expensive for

value received; (8) too tired; (9) programs and courses available too low in quality; (10) other obstacles (not identified in the questionnaire); and (11) ill health. "Insufficient time due to patient care load" was also ranked first by the physicians at the 1973 Refresher Course, and similarly, by a margin almost twice as great as the next most important obstacle. The second and third most important obstacles to continuing medical education checked by the latter group were: (2) insufficient time due to personal factors; and (3) too much time getting to and from program sites.

#### IV. PLANNING

All of the various methods of continuing medical education identified in Section II were restated in general terms so that we could ask the question: Which method of continuing medical education is most important? This question is different from the one concerning the effectiveness of each method since it is possible for physicians generally to consider a particular method important and also to rate it low in effectiveness. The general restatement included two methods of continuing medical education where the individual physician is the sole actor in the educational process, and four methods where the physician interacts with other physicians and medical educators. Table 8 presents the responses from both the random sample physicians and the physicians attending the 1973 Refresher Course.

Seventy-one per cent of the surveyed physicians think continuing medical education will soon become a requirement (i.e., other than a professional or personal goal). The counterpart response by the Refresher Course physicians was 83 per cent. If it does become a requirement, the physicians feel the number of continuing education hours of all types required should be approximately 25 hours (median) annually. The data are presented in Table 9.

If documentation of continuing medical education becomes a nationwide necessity, the surveyed physicians would most prefer their specialty boards to handle the documentation and certification procedures. Their second and third choices were: (2) specialty society; and (3) county medical society. The remaining alternatives appearing on the questionnaire were (in the order of their selection): (4) state medical so-

TABLE 9

OPINION ABOUT REQUIRED CME TIME PER YEAR,

IF A REQUIREMENT WERE IMPOSED

ours		Physicians	Refresher Course Physicians Per Cent
0	[[[[[]]]]]	21	8
5	. ,	28	20
0		9	8
0		28	54
_			4
0		7	5
ore tha	n 100	3	1
Total .			100

ety; (5) medical school in the area; (6) local ospitals; (7) AMA; (8) a "council" or "comittee" drawn largely from all of the alternatives entioned; (9) State board of medical licensure; ad (10) a new government agency.

The three most preferred alternatives selected y the Refresher Course physicians were: (1) ate medical society; (2) medical school in area; ad (3) county medical society.

Table 10 presents the responses of the two coups of physicians regarding which types of ertification or membership they felt should reuire documentation of continuing medical eduction, if such requirement were to become a ecessity. They were asked to mark all the opons they thought appropriate, and so the reponse total is greater than 100 per cent.

Which organization should assume the primary

TABLE 10

RELATIONSHIP BETWEEN DOCUMENTED CME AND ITS POTENTIAL REQUIREMENT FOR MEMBERSHIPS, ERTIFICATION, STAFF APPOINTMENTS AND RELICENSURE

Ra	Physicians	e Refresher Course Physicians Per Cent
ontinued specialty certification ontinued professional members		60
(AAFP, ACP, ACS, etc.)	61	66
ospital staff appointments	59	53
elicensure by State		54
ciety		38
ciety	33	40
ontinued membership in the A	MA 26	35

responsibility for identifying educational needs and planning and evaluating the continuing education of physicians? The physicians in our survey would most prefer their specialty boards to fulfill this role. Their second preference is their specialty societies and their third is medical schools. The remaining alternatives identified in the questionnaire, in the order of their ranked importance, are: (4) county medical societies; (5) state medical society; (6) local hospital staff; (7) a "council" or "committee" drawn largely from a combination of all the alternatives identified; (8) American Medical Association; (9) State board of licensure; and (10) a new government agency. In contrast, the first three alternatives selected by the physicians at the 1973 Refresher Course were: (1) state medical society; (2) medical schools; and (3) specialty societies.

TABLE 11

THE NEED FOR ACCREDITING LOCAL OR COMMUNITY LEVEL CME ACTIVITIES

			Per Cent
Great need			19
Moderate need		. 1	48
Small need			22
No need			11
Total			. 100

We asked the physicians, finally: Is there a need to accredit continuing medical education activities at the local or community level? The responses are presented in Table 11.

#### COMMENTS

The large amount of information in this report will say something different to each reader. From our educational point of view some elements of data seem more important than others. The following comments deal with those we feel are especially important findings.

The fact that an overwhelming number of physicians in both samples checked "insufficient time due to patient care load" as *the* most important obstacle to continuing medical education is frustrating from both points of view: practitioners' and medical educators'. We see a need to foster a greater change in physicians' attitudes towards potential palliatives: more efficient practice management, group practice, and the utilization of health care auxiliaries. The answer may not be as

simple as educating more and more physicians. A greater willingness to experiment with new forms of health care delivery may lead to a less hurried practice.

Another obstacle to continuing medical education concerns the quality and utility of educational offerings. Improvement in the quality and usefulness of educational offerings depends heavily on effective communication between practitioners and educators, especially when this communication involves attempts to accurately assess educational needs. Past efforts at identifying needs usually relied on the impressions of medical educators or the impressions of community physicians serving in a leadership or activist role. It is now possible to test many of the impressions on educational needs before resources are expended, perhaps unwisely. By comparing locally developed norms or standards of care to the patterns of care actually rendered, physicians can assess, in a more accurate and objective manner, the types of educational experiences needed. Unfortunately, the data indicate that the great majority of Iowa physicians have not yet realized the utility of this

The fact that the surveyed physicians identified "too much time getting to and from program sites" as another significant obstacle to continuing medical education reflects basic economic constraints. Offering high quality educational programs on a regular basis in more locations would require more educational resources of all types.

The growing concern for documenting continuing medical education causes us to note that not all its forms are externally "documentable." Among those certifiable as to presence or enrollment of the physician are hospital conferences, post-graduate lectures, symposia and courses sponsored by various organizations, home study courses and self-assessment examinations. How does one "document" the valuable and considerable learning that may accrue via reading, colleague consultation, audio-tapes, teaching, research, writing or other innovative methods that are highly individual and private? And, of course, how does one find the formula to relate "spends time" to "learn" to "changes behavior" to "improves health care given?"

If, in describing what physicians do for their continuing medical education, one uses only the "documentable" kinds of CME activities instead of the entire spectrum, the results are inaccurat and misleading. For example, the data indicat that about 34 per cent of the sampled physiciar did not participate in more than 50 hours of "documentable" CME during the past year; abou 29 per cent did not participate in more than 4 hours of documentable CME; about 16 per cer did not participate in more than 30 hours; about 9 per cent did not participate in more than 2 hours, and about 4 per cent did not participat in more than 10 hours.\* Yet we also know that the very lowest time spent in all kinds of continu ing medical education activities reported by an one physician in the entire sample was slightl more than 100 hours per year, with the overa median approximately 350 hours\* per year! Th demonstrates the importance of admitting a c versity of educational experiences before concluing that a practitioner is not engaged in contining education activity.

If continuing medical education is broadly conceived, as we feel it should be, then we may safely conclude that practicing Iowa physician are currently devoting an extraordinary amount of time, effort and money in the process of the professional education. We are even justified a speaking of a "Continuing Medical Education Day" given out of each week by the average practitioner.

That 71 per cent of the sampled physicians e pect soon some sort of continuing education r quirement, is surely an important finding. If th expectation materializes, then the profession we face an increasing challenge to assure for itse high-quality educational experiences that resport to locally identified needs, plus a satisfactor method for accrediting or documenting ear physician's attainment in a manner that we satisfy the profession and those outside it who as clamoring for the evidence of highest qualical health care. A carefully structured effort, developed collaboratively with all elements of the medical profession, will be required to achieve such a goal.

#### REFERENCES

<sup>\*</sup> The reader is reminded that these numbers fail to refl time spent at continuing education meetings and courses spe sored by medical specialty societies.

<sup>1.</sup> Aschoff, C. R.: "Report of Committee on House of Delegas Apportionment," J. Iowa Med. Soc., 63:306, July, 1973.
2. Bale, Guru S. et al: Survey of Physicians; Iowa—1972. Is Moines, Iowa State Department of Health, 1973.

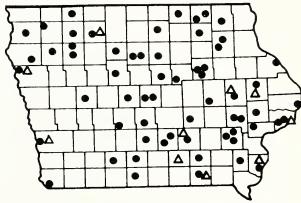
## The College Thanks Iowa Preceptors

In the 1972-73 academic year, two classes of medical students served preceptorships in primary care. For the graduating class of 1973, 10 physicians from 10 Iowa communities served as preceptors for 10 senior students. This group of students participated in an elective senior preceptorship in primary care, made available through a federal grant. For the class of 1974, 107 physicians from 62 Iowa communities were preceptors for 140 junior medical students. The preceptorship in the junior year is required for a period of two weeks.

Although the individual preceptors listed here identify the one principally responsible, many other physicians have contributed to this important educational program. Group practices and "student-sharing" among solo practitioners permitted students to encounter multiple practitioners, and correspondingly, a variable number of physicians enjoyed the stimulation of contact with bright young student physicians. To all these groups and individuals the College of Medicine extends sincere appreciation and respect.

This program is an important element in our

outreach effort—to permit students to have a look at clinical problems and opportunities of medical practice away from the academic health center. The students value this portion of the curriculum.



Class of 1973 • Class of 1974

Increasing numbers of them will be choosing elective preceptorships in their senior year. For the great interest and cooperation of so many busy, practicing physician teachers, the College of Medicine is deeply grateful.

#### 1972-73 PRECEPTORS FOR THIRD YEAR REQUIRED PRECEPTORSHIP

#### 

Cedar Rapids	
M.D., G. VanSlyke, M.D.	
Cherokee Daniel Sheehan, M	.D.
J. H. Wise, M.D.	
Clarion Rober Eaton, M	.D.
Clinton G. D. Aurand, M	.D.
Conrad Glendon Button, M	.D.
Coralville Philip McLaughlin, M	.D.
Charles Skaugstad, M.D.	
Council Bluffs Irving Hanssmann, M	.D.
Cresco Peter Kepros, M	.D.
Creston William Fisher, M	.D.

Davenport	Knoxville Earl McKeever, M.D. Leon Thomas McMillan, M.D.
Decorah James Bullard, M.D.  I. F. Green, M.D.	Mason City
Denver Ernest Stumme, M.D.	Monticello A. L. McDermott, M.D.
Des Moines	Mt. Pleasant
M.D., Stewart Olson, M.D., Roy Overton, M.D., Donald	Nevada Jerald King, M.D.
Schissel, M.D., Robert Smith, M.D.	New Hampton D. R. Olsen, M.D.
Dexter Robert Osborn, M.D.	Orange City
Dubuque J. S. Chapman, M.D.	Osage
Eugene Coffman, M.D., Volney Hash, M.D., David Kapp,	Osceola James Kimball, M.D.
M.D., F. B. Merritt, M.D.	Oskaloosa
Eagle Grove	Ottumwa Ed Ebinger, M.D.
Elma Curtis Rainey, M.D.	John Rawls, M.D.
Emmetsburg James Coffey, M.D.	Pella Stewart Kanis, M.D.
Lowell O'Connor, M.D.	Sheldon Ronald Zoutendam, M.D.
Fort Dodge F. G. Dannenbring, M.D.	Sioux City
Gary LeValley, M.D.	William Jackson, M.D., H. E. Rudersdorf, M.D., Dan Young-
Grinnell H. R. Light, M.D.	blade, M.D.
Hamburg F. M. Ashler, M.D.	Sioux Rapids
Hampton Donald Benge, M.D.	Spencer John Kelly, M.D.
Humboldt James Coddington, M.D.	Ed Schlichtemeier, M.D.
Indianola S. F. Yugend, M.D.	Spirit Lake Donald Rodawig, M.D.
lowa City Oscar Beasley, M.D.	Storm Lake T. E. Shea, M.D.
Thaddeus Bozek, M.D., Victor Edwards, M.D., Larry Rigler,	Tipton Otto Kruse, M.D.
M.D., M. Craig Champion, M.D., Anthony Colby, M.D.,	Washington Gerald Nemmers, M.D.
Loraine Frost, M.D., Kenneth Judiesch, M.D., Karl Larsen,	Waterloo
M.D., John Maxwell, M.D., Thomas Nicknish, M.D., Wayne	Ronald Rath, M.D.
Tegler, M.D.	Waverly James Rathe, M.D.
Iowa Falls Robert Dunlay, M.D.	Wellman J. R. Miller, M.D.
Kalona Dwight Sattler, M.D.	West Liberty Howard Palmer, M.D.
Kingsley Robert Powell, M.D.	West Union Larry Boeke, M.D.
1972-73 PRECEPTORS FOR FOURTH	YEAR ELECTIVE PRECEPTORSHIP
SERVED STUDENTS FROM CLASS OF 1973	Cedar Rapids
	Council Bluffs F. J. Klok, M.D.
Albia Donald Orelup, M.D.	Davenport Edwin Motto, M.D.
Anamosa Aaron Randolph, M.D.	Emmetsburg James Coffey, M.D.
Bloomfield Mark Pabst, M.D.	Oskaloosa
Burlington Jo Ellen Hoth, M.D.	Sioux City George Spellman, M.D.

#### ACKNOWLEDGE SERVICE OF IOWA PHYSICIANS

The University of Iowa College of Medicine wishes to express appreciation to those members of the practicing community who currently serve on its various standing committees. The perspec-

#### **ADMISSIONS**

John Tyrrell, M.D., Manchester Robert Whinery, M.D., Iowa City

#### COMMITTEE ON CANCER

L. Robert Martin, M.D., Cedar Rapids Regis Weland, M.D., Cedar Rapids tive brought by these practitioners is most welcome in our deliberations. Their willingness to devote so generously of themselves is gratefully acknowledged.

#### CONTINUING MEDICAL EDUCATION

Arthur Barnes, M.D., Cedar Rapids David Kapp, M.D., Dubuque John MacGregor, M.D., Mason City John Murphy, M.D., Boone Donald Ottilie, M.D., Oelwein Roy Overton, M.D., West Des Moines

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# Editorials

M. E. ALBERTS, M.D., Scientific Editor

#### ANNUAL UNIVERSITY ISSUE

Semantics is the study of meanings, especially of words. Herein rests the interesting part of being an editor. Yet, when one wishes to express a meaning, words sometimes fall short.

It is our custom and pleasure to dedicate this issue of your JOURNAL to the University of Iowa College of Medicine. Our colleagues in the aca-

demic world of medicine mean much to us. Oftimes the practicing physician may be miffed by the academic climate, but still admits the worth of the dedicated instructors and researchers in the educational institution. We need them; they need us.

With no further need to analyze our meaning, we honor the College of Medicine. The College in turn honors us with their efforts. We hope you, the reader, will find interest in this issue of the JOURNAL.—M.E.A.

#### ON ROSES & PRESCRIBING

Recent announcements from Secretary Caspar W. Weinberger indicate HEW proposes to limit reimbursements for prescription drugs under Medicare and Medicaid to the "least possible cost at which the drug is generally available." This is particularly disturbing.

Under this plan payments will be based on the least expensive so-called generic drug. Little or no mention is made of quality. The end result could be second grade medications for many Medicare and Medicaid patients. Such arbitrary action takes from the physician his time-honored prerogative to prescribe as his good judgment dictates. The victims of such short sighted Washington dealings are our patients. Those governmental officials who trifle with the practice of medicine should realize that the totality of care for a patient must encompass the selection of a specific medication.

Gertrude Stein said, "a rose is a rose is a rose" but equivalence of the generic concept can not be compared with roses. I am sure the governmental generic advocates would be upset if the florist delivered bedraggled birthday roses of various sizes and colors to their wives. After all, they're roses. What do they care as long as they were cultured, ordered and shipped. Of course, the little lady doesn't mind! After all, she understands things like that! Or does she? I bet she would call the florist and demand replacement with the best quality roses.

How can the aged Medicare patient know if he/she has received cheap, poor quality, low potency medication. Dear Sirs in Washington: my mother is on Medicare. If you want her to have medicine based only on cost, please, call me so I can defend to the fullest of my ability the right of her doctor to prescribe the specific medication he wants her to have for her glaucoma. She deserves the best; not something from a questionable manufacturer who happens to be in business to capitalize on the whims of government.—M.E.A.

### IMS PART OF BUSTLING UNIVERSITY SCENE IN APRIL

POTPOURRI of facts and figures about the University of Iowa Hospitals and Clinics is contained in an impressive 75th Anniversary Report to Friends and Colleagues distributed earlier this year. This excellently illustrated booklet affords a panoramic look at the dynamic Iowa City health complex.

In a further commemoration of the 75th Anniversary, Iowa physicians—from all across the state—will join the bustling scene at University Hospitals this month for a special event. The Iowa Medical Society will present its 1974 Scientific Session at The University of Iowa on April 18, 19 and 20.

In this three-day period, participating physicians—from Clinton to Council Bluffs—will be on campus to find out what's new in medicine—from anesthesia to urology. This is one of the important continuing medical education events available in 1974 to Iowa physicians.

What kinds of topics are slated for discussion? Well, they cover a good bit of the medical care spectrum. Here, for example, are several titles lifted from the program: Control of GI Bleeding, Family Planning, Transfusion Reactions, Managing Urinary Tract Infection, and Surgical Procedures in Medical Emergencies. These headings permit a measure of understanding even for the non-physician. However, there are some esoteric titles which test the mind: Coronary Arteriography, Peripheral Vascular Disease, Hypertension of Renal Origin, and Fluids and Electrolytes.

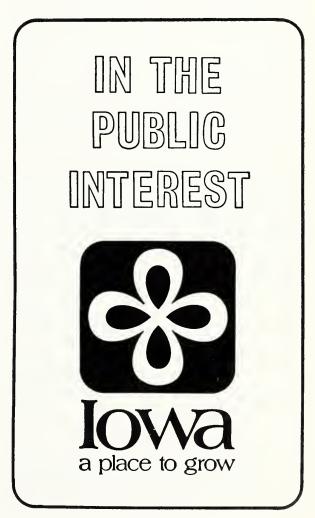
A full afternoon is set aside for physician visitation to any of the clinical departments at University Hospitals. Open to Iowa physicians will be the Departments of Anesthesia, Dermatology, Family Practice, Internal Medicine, Neurology, Obstetrics & Gynecology, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pediatrics, Radiology, Surgery and Urology.

Acknowledgement is due the several individuals who have had a part in planning this diversified continuing medical education event. Fittingly, the 1974 Scientific Session is at University Hospitals, for the Society President this year is a senior and respected member of the College of Medicine faculty. IMS President Rubin H. Flocks, M.D., is professor and head of the Department of Urology. At his suggestion, appropriately, the

University of Iowa campus was selected as the site for the 1974 IMS Scientific Session.

The planning began in May, 1973, with a program committee named to serve under the chairmanship of R. D. Whinery, M.D., Iowa City. His compatriots on this 1974 Program Committee are R. M. Caplan, M.D., Iowa City, L. J. Gugle, M.D., Ottumwa, C. P. Hawkins, M.D., Clarion, J. F. Murphy, M.D., Boone, H. J. Smith, M.D., Des Moines, J. E. Tyrrell, M.D., Manchester, and S. E. Ziffren, M.D., Iowa City. These physicians have assembled a topflight continuing education program which will be of ultimate benefit to the citizens of Iowa.

Gratitude is due the 50 or more College of Medicine faculty who will share their knowledge during the three-day period. The program is in-



formal in large measure, and as a result, ample opportunity will exist for productive exchange between the participating faculty and the practicing physicians.

#### NOTEWORTHY ANNIVERSARY

The seventy-fifth anniversary of the University of Iowa Hospitals is most noteworthy. The fact that the Iowa Medical Society Scientific Session is in the campus environs on this occasion is mostly coincidental. The following random thoughts taken from the commemorative booklet underscore the importance of this facility to the people of Iowa.

LONG-TIME SERVICE—"In the 45 years University Hospitals has existed in its present location, it has provided care to nearly one million individual patients. Of this total, approximately 80%, or 800,000 patients, have been Iowans—this number representing 517,000 different Iowa family units. University statisticians have recently determined that Iowa has had some one million different family units in existence during the past 45 years, thus indicating that the University Hospitals has served one of every two Iowa family units during the past four decades."

CHANGING TIMES—". . . The evolution of social insurance programs, such as Medicare and Medicaid, has resulted in the indigent proportion of the hospital's patient census falling from a level of 75% in 1950, to 60% in 1960 and down to approximately 33% at the present time. The decreasing number of patients referred on an economic basis has been accompanied by an even greater replacement of new patients made up of those referred to University Hospitals on the basis of the broad scope clinical competency now available in the complex. Accompanying this change in clientele has been a 233% growth in medical and dental staff, nurses, and other professional and supporting staff, and an appropriately heavy investment in the scientific hardware necessary for patient care, teaching and clinical research. These investments have resulted in making the University Hospitals a regional referral center, encompassing the full spectrum of primary, secondary and tertiary clinical services with a rapidly increasing emphasis on the tertiary level at the present time."

MAGNITUDE—"Within the University Hospital's complex on any given weekday are some 600 physicians practicing their skills in 15 specialty and 47 subspecialty clinical divisions. They

are joined by 2,000 other health team professionals and supporting staff in caring for approximately 2,000 patients—1,000 on inpatient nursing units and 1,000 ambulatory patients receiving treatment and diagnosis in the institution's multidisciplinary ambulatory clinics. These human elements, coupled with some 1,800 students, 900 visitors, make up a total daily institutional population of 7,000 vitally concerned human beings."

STATEWIDE RESOURCE—"... every county in Iowa is represented in the 31,457 patients admitted to University Hospitals last year (1973) and the 261,000 patient visits to the institution's ambulatory care clinics..."

STAFF—"The 643-doctor medical and dental staff at University Hospitals operates through a multi-specialty clinical service structure. Each clinical service is organized as a separate clinical and administrative department within the University Hospitals, with the chief of each service being responsible for the overall supervision of the clinical service, teaching and research functions within his respective service. Each department establishes its own modus operandi consistent with policies of the University Hospital and the Colleges of Medicine and Dentistry, and overall sanction of the University President and the State Board of Regents . . ."

EDUCATION PROGRAMS—"Health science educational programs conducted within University Hospitals presently number 27 and involve some 1,800 students. These programs include students in dentistry and dental hygiene, nursing, pharmacy, orthopaedic assisting, physical therapy, undergraduate medicine, pastoral study, nuclear medicine, medical and X-ray technology, hospital and health administration, as well as residents and interns in oral surgery, dietetics, pharmacy, and most all disciplines of medicine."

". . . University Hospitals has assumed a primary role in sponsoring graduate medical education programs currently involving some 400 physicians and dentists engaged in specialty training in residencies and internships based at University Hospitals, the state's Veterans Administration Hospitals and several affiliated Iowa community hospitals."

It is into this exhilarating setting that many of Iowa's physicians will be moving for a brief April educational experience. Viva Iowa Medical Society Scientific Sessions! Viva University Hospitals!

# State Department of Health

#### APPROVED PREMARITAL & PRENATAL BLOOD TESTING LABORATORIES

It has come to the attention of the Iowa State Department of Health that some blood samples taken for seriologic testing for syphilis have been sent to out-of-state or non-approved laboratories. These tests are required by law for marriage license applicants and for pregnant women.

The Code of Iowa in Chapter 140 states that "each physician attending a pregnant woman in this state shall take or cause to be taken a sample of blood of each such woman within 14 days of the first examination, and shall submit such sample for standard serological tests for syphilis to the State Hygienic Laboratory of the State University at Iowa City or some other laboratory

approved by the State Department of Health." Regarding the premarital blood tests, the law again requires that physicians send samples either to the State Hygienic Laboratory or to approved laboratories.

These provisions in the Code of Iowa were enacted to assure the reliability of the test results.

Therefore, in order for the physicians to protect themselves and their patients, we urge that physicians send blood samples to approved laboratories or to the State Hygienic Laboratory, State University of Iowa, Iowa City.

For the convenience of physicians, a list of currently approved laboratories follows:

Albia—Monroe County Hospital Laboratory
Ames—Mary Greeley Hospital Laboratory, Clinical Laboratories, P.C.

Anamosa—Anamosa Community Hospital Laboratory
Bloomfield—Davis County Hospital Laboratory
Boone—Boone County Hospital Laboratory
Burlington—Memorial Hospital Laboratory, North Hill Medical Laboratory

Carroll—St. Anthony Hospital Laboratory
Cedar Falls—Sartori Memorial Hospital Laboratory
Cedar Rapids—Mercy Hospital Laboratory, St. Luke's Methodist Hospital Laboratory, Weland Clinical Laboratory
Centerville—St. Joseph Mercy Hospital Laboratory
Chariton—Lucas County Memorial Hospital Laboratory
Cherokee—Sioux Valley Memorial Hospital Laboratory
Clinton—St. Joseph Mercy Hospital Laboratory

Corydon—Wayne County Hospital Laboratory
Council Bluffs—Pathology Services, P.C., Mercy Hospital Laboratory

Cresco—St. Joseph Mercy Hospital Laboratory
Creston—Greater Community Hospital Laboratory
Davenport—Davenport Osteopathic Hospital Laboratory,
Mercy Hospital Laboratory, Quad Cities Pathologists Group
Laboratory, St. Luke's Hospital Laboratory
Denison—Crawford County Memorial Hospital Laboratory

Des Moines—Clinical Pathology Laboratory, College of Osteopathic Medicine and Surgery Laboratory, Community Blood Bank of Central Iowa, Des Moines General Hospital Laboratory, Iowa Lutheran Hospital Laboratory, Iowa Methodist Hospital Laboratory, Mercy Hospital Laboratory, Northwest Hospital Laboratory, Pathology Associates, U. S. Veterans Hospital Laboratory

Dubuque—Dubuque Blood Bank Association Laboratory, Finley Hospital Laboratory, Medical Associates Laboratory, Mercy Medical Center, Xavier Hospital Laboratory

Estherville—Holy Family Hospital Laboratory

Fort Dodge—Bethesda General Hospital Laboratory, Fort Dodge Mercy Hospital Laboratory

Fort Madison—Sacred Heart Hospital Laboratory Hampton—Franklin General Hospital Laboratory

Iowa City—Mercy Hospital Laboratory, U. S. Veterans Hospital Laboratory

Jefferson—Greene County Medical Center

Keokuk—Graham Hospital Laboratory, St. Joseph Hospital Laboratory

Manchester—Delaware County Memorial Hospital Laboratory Maquoketa—Jackson County Public Hospital Laboratory

Marengo-Marengo Memorial Hospital Laboratory

Marshalltown—lowa Soldiers' Home Laboratory, Marshalltown Area Community Hospital Laboratory

Mason City-Park Clinic Laboratory, St. Joseph Mercy Hospital Laboratory

Mt. Pleasant-Henry County Memorial Hospital Laboratory Nevada—Story County Hospital Laboratory New Hampton-St. Joseph Hospital Laboratory Newton-Mary Frances Skiff Memorial Hospital Laboratory Oelwein-Mercy Hospital Laboratory Orange City—Orange City Municipal Hospital Laboratory Oskaloosa—Mahaska County Hospital Laboratory Ottumwa—Southeast Iowa Blood Bank Laboratory Pocahontas—Pocahontas Community Hospital Laboratory

Sioux City-St. Joseph Mercy Hospital Laboratory, St. Luke's

Medical Center Laboratory, St. Vincent's Hospital Laboratory, Sioux City Health Department

Spencer—Spencer Municipal Hospital Laboratory Storm Lake—Buena Vista County Hospital Laboratory

Waterloo-Allen Memorial Hospital Laboratory, Black Hawk Medical Laboratory, St. Francis Hospital Laboratory, Schoitz Memorial Hospital Laboratory, Waterloo Regional Red Cross **Blood Center** 

Waukon-Veterans Memorial Hospital Laboratory Waverly-St. Joseph Mercy Hospital Laboratory Webster City—Hamilton County Hospital Laboratory

#### DARKFIELD MICROSCOPY SERVICE AIDS IN DIAGNOSIS OF PRIMARY & SECONDARY SYPHILIS

As a new direct service, the Iowa State Department of Health has initiated a program of darkfield microscopic examination of specimens to assist physicians in the diagnosis of primary and secondary syphilis. A physician wishing to request this service should contact the Iowa State Department of Health, Venereal Disease Division, Lucas State Office Building, Des Moines, Iowa 50319—(515) 281-3031 (collect). A trained state health department representative will be dispatched with the necessary equipment to assist the requesting physician.

Darkfield examination of a suspected primary

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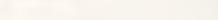
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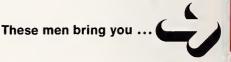


Chris Shibel









<sup>\*</sup>For more information on the history of your state, write Professional Services, Marion Laboratories, Inc.

syphilis lesion may be of special diagnostic value when the lesion is atypical. In addition, this type of examination may provide a rapid confirmation of diagnosis when the "classical chancre" is highly suggestive of primary syphilis. Early serologic confirmation may not be possible since serologic tests are often nonreactive at time of appearance of the primary lesion and become positive during the following 1 to 4 weeks. Syphillis should be suspected when an ulcerated genital or anal lesion is observed, and darkfield examination should be performed prior to administration of antibiotic therapy.

Darkfield examination of material from other than mouth lesions, is diagnostic if organisms resembling *T. pallidum* are seen. Patients who are found to be either positive or negative by darkfield examination should be serologically tested concurrently and serologic tests for syphilis should be done weekly for at least three weeks, to insure against missed diagnoses due to "false negative" lesions. Darkfield microscopy is viewed

as an adjunct to, and not a replacement for, sero-logic testing.

Lesions of primary syphilis develop at the site of inoculation anywhere from 10 to 90 days after infection, usually appearing at about 21 days.

Secondary syphilis is more varied in its clinical manifestations, causing a wide variety of lesions on any cutaneous or mucosal surface. Viable treponemes are usually present in secondary syphilis lesions, and therefore darkfield examination of these lesions may be of diagnostic significance as well as during the primary stage. Serologic tests for syphilis should always be positive in this stage of disease.

The increase in reported syphilis cases in Iowa (7.7% increase in 1973) has created, among clinicians, an increased awareness of the need for a high index of suspicion for primary and secondary syphilis. Complete and rapid reporting of suspected cases, as well as rapid specific diagnoses, are essential as a first step toward interrupting the transmission of this devastating disease.

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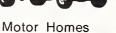
Description: Each capsule contains 400 mg of nicotinic acid in a special base that provides a prolonged systemic effect. Indications: NICO-400% is recommended for all disease states in which nicotinic acid has been used. These include conditions associated with deficient circulation and for use in the correction of nicotinic acid deficiencies. Contraindications: Individuals with a hypersensitivity to nicotinic acid, severe hypotension or hemorrhaging warnings: Use with caution in those patients with history of opptic ulcer, severe diabeles, impaired gall bladder or liver functions and in pregnant women. Adverse Resctions: Patients should be informed of the shri-lived reactions experienced with nicotinic acid therapy cutaneous flushing, a sensation of warmth, tingling and Itching of the skin, increased gastrointestinal motility and sebaceous gland activity. Dosage and Administration: One capsule every 12 hours or as directed by physician. Caution: Federal law prohibits dispensing without prescription. How Supplied: Bottles of 100 capsules

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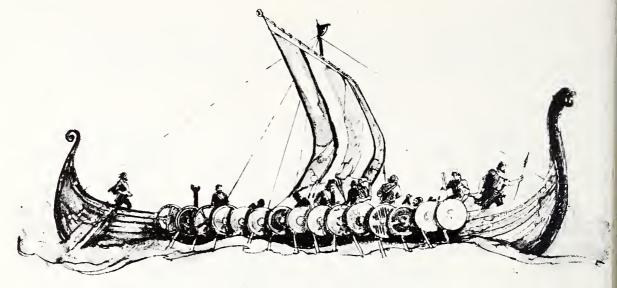
#### Morbidity Report for February, 1974

		1974	1973				1974	1973	
	Feb.	to	to	Most Cases Reported		Feb.	to	to	Most Cases Reported
Disease	1974	Date	Date	From These Counties	Disease	1974	Date	Date	From These Counties
Adenovirus					Meningitis, type				
infection	2	8		Dallas, Poweshiek	unspecified	4	8	6	Black Hawk, Johnson,
Brucellosis	3	3		Dubuque, Story, Tama					Linn, Webster
Chickenpox	1217	1950	4118	Scattered	Meningitis,				
Conjunctivitis	74	101	136	Scattered	bacterial	2	2		Clayton
Cylomegalovirus					Meningococcal				
infection	1	13		Polk	meningitis	2	3		Clayton, Johnson
Eaton's agent					Mixed inf. (Eator	n's			
infection	8	15	5	Henry, Linn, Polk, Scott,	agent & flu)	2	2		Clayton, Fayette
				Johnson	Mumps	379	674	1049	Black Hawk, Hancock,
Encephalitis, type					Pediculosis	46	79	36	Johnson, Poweshiek Scattered
unspecified	4	5	5	Audubon, Carroll,	Pertussis	2	3	2	
				Johnson, Wayne	Pinworms	1	18	2	Buchanan
Encephalitis, vira		3	2	Cerro Gordo, Iowa, Scott	Pityriasis rosea	i	1		Story
Enteropathogenie	c				Pneumonia	116	209	295	Scattered
E. Coli	1	2		Dubuque	Rabies in animals		21	43	Scattered
Erythema					Rheumatic fever	27	32	5	Black Hawk, Bremer,
infectiosum	25	49	227	Calhoun, Madison,			-	•	Calhoun, Warren
				Pottawattamie, Warren	Ringworm, body	19	54	28	Calhoun, Johnson,
Gastrointestinal				direii					Pottawattamie
viral inf.	1656	2376	2979	Ida, Jackson, Johnson,	Rubella	3	5	76	Lucas, Marshall, Van Buren
				Linn, Mahaska	Roseola	5	5		Black Hawk, Clay,
Hepatitis,									Franklin, Wapello
infectious	20	62	34	Johnson, Marion,	Salmonellosis	8	25	9	Chickasaw, Linn, Mills,
				Muscatine, Polk					Sac, Story
Hepatitis, serum	10	16	10	Dubuque, Johnson, Polk,	Scabies	23	28	1	Johnson, Linn, Muscatine
				Pottawattamie	Shigellosis	8	19	54	Cerro Gordo, Johnson,
Hepatitis, type									Polk, Warren
unspecified	4	4		Buchanan, Hamilton,	Streptococcal				
	_			Linn, Washington	infections	1609	2532	1381	Clinton, Jackson,
Herpes simplex	7	15		Iowa, Johnson, Jones,					Johnson, Polk
	•			Muscatine	Tuberculosis,				
Herpes zoster	3	10	- 1	Johnson, Mahaska,	active	4	14	24	Dubuque, Fayette,
Min of the control	,	•		Monroe					Muscatine, Polk
Histoplasmosis Impetigo	3	3		Henry, Linn, Polk	Tuberculosis,				
Infectious	44	61		Scattered	inactive	- 1	ı		Scott
	00	100		81 1 1 1 1 1	Vincent's angina	3	3		Dubuque, Van Buren
mononucleosis	90	182	151		Venereal diseases				
Influenza-like				Linn	Syphilis	32	85	42	Iowa, Linn, Polk, Scott,
-44	49229	51117	4220	Scattered	C L.	400	1017	047	Woodbury
Influenza,	71227	51117	6339	Scattered	Gonorrhea	480	1016	846	Black Hawk, Johnson,
lab confirmed	46	46	E 1	Clautan John	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Linn, Polk, Scott
ab commined	40	40	51	Clayton, Johnson,	Lymphogranulo				Union
				Mitchell, Polk	ma venereun	1	1		Union

DIABETIC CAMP . . . Camp Hertko Hollow, Iowa's Camp for Diabetic Youth, will be from June 30 to July 6 at the Des Moines YMCA Camp. Additional information is available from IMS Headquarters.

**PSRO...** Organizational requirements now being developed by the National PSRO Council may necessitate modifications in the existing relationship between the Iowa Foundation for Medical Care and the IMS for PSRO purposes.

# Come To The Land Of The Vikings



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# Medical Assistants

by TENORA MEYER, CMA

#### FORWARD WITH FINESSE

The members of the Sioux City Chapter of the American Association of Medical Assistants invites all Iowa medical assistants to go "FOR-WARD WITH FINESSE" as they host our 18th annual convention. The convention will be May 3, 4 and 5 at the Aventino Motor Inn, 517 6th Street, Sioux City.

Convention chairman is Pauline Tappan; vice chairman, Cathy Schmitt; and program chairman, Celia Dermit.

Registration will begin Friday, May 3, at 4 p.m., followed by an Executive Council meeting. A Friday evening hospitality party will be on the "Happiness Is" Theme. Campaigning will conclude the Friday events.

The Mini-test will be given Saturday at 7:30 a.m. This is a simulated certification test which touches on areas covered in the actual examination. Passing the Mini-test lends encouragement to sit for the certification test. It includes two sections—administrative and clinical.

A featured convention speaker will be Luella Mitchell, National Trustee, Chicago, Illinois. She

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

will discuss "Parliamentary Law" Saturday morning. Ms. Mitchell is employed by E. E. Hasbrouck, M.D., Chicago, and has been very active in national, state and local activities of AAMA. She has participated in "The Effective Speaking Seminar Team" throughout Illinois.

Pauline Tappan, State Safety Chairman, has organized an informative and significant safety program for Saturday afternoon. The Saturday evening banquet will have the theme "An Array of Beauty." The Chordsmen will entertain with Sioux City TV personality Don Stone as master of ceremonies.

Installation of officers will occur Saturday evening. President-elect JoAnn James of Mason City will be installed as 1974-75 president. She is employed by L. C. Orton, M.D., of Mason City. Outgoing president is Sally Gesink of Sioux City.

On Sunday morning, a panel discussion, "Dual Review," will be presented. This is designed to stimulate interest in the CMA program and will give everyone the opportunity to acquire information in preparation for the certification examination.

For further information on the convention, you may write Mrs. Pauline Tappan, 4865 Skyline Drive, Sioux City, Iowa 51104.

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hen you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although

some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

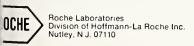
# symptom complex o Valium<sup>®</sup> (diazepam)

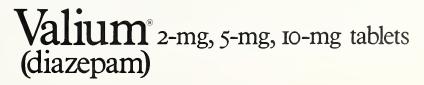
Precautions: If combined with er psychotropics or anticonvults, consider carefully pharmagy of agents employed; drugs has phenothiazines, narcotics, biturates, MAO inhibitors and er antidepressants may poteneits action. Usual precautions icated in patients severely dessed, or with latent depression, with suicidal tendencies. Observe al precautions in impaired renal

or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred

vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.





# President's Page

This month it's my pleasure to pass the presidential gavel to Ralph Wicks. In doing so, I bid him well in the coming year. Too, I extend sincere thanks to those who have made my year as principal spokesman for the Iowa Medical Society personally rewarding.

Any full assessment of Medicine (Volume 1973-74) will be left to the historian. Obviously, we continue to have uncertain conditions. We've been heartened by the firmness of the AMA in Cost of Living, PSRO, pre-certification, etc., activities. At the state level, the IMS, the Iowa Foundation for Medical Care and the Scanlon Medical Foundation have represented the interests of the profession and the public in a variety of ways—and with a modicum of success.



My first President's Page had a concluding admonition which is as appropriate now as it was then (and will continue to be):

"It is extremely important for all of you to become involved and participate so we can meet the challenges of society in a coordinated manner. This will enable us to achieve the best of medical care for everyone in the state, and at the same time make sure we all can practice medicine in the best way possible for everyone concerned. Become involved in organized medicine and together we will solve the problems in a constructive manner."

Best wishes.

Sincerely,

Rubin Flocks, M. D.

Rubin Flocks, President



URGE RESTRAINT . . . Anticipated end of control on physicians' fees April 30 was noted by Society President Rubin Flocks, M.D., at close of recent IMS scientific session. Dr. Flocks urged those present to increase fees only as necessary to keep pace with inflation. AMA has announced extensive informational program to assist physicians in making equitable decisions about fees.

**LEGISLATION** . . . Much-opposed chiropractic measure cleared House and Senate in April. New law does prohibit chiropractors from advertising. Proposal to revamp professional and occupational licensing boards is awaiting final approval as this is prepared. Bills relating to generic prescribing, optometry and patient records appear stymied for this session.

PHYSICIAN ASSISTANTS . . . IMS Board of Trustees is spearheading further evaluation of the role of the PA in Iowa. Near-future meeting will involve representatives of various organizations and will follow-up on a March 20 discussion.

**SPECIALTY SERVICE...** IMS Board of Trustees has authorized a stepped-up program of administrative service to interested specialty groups; several groups now use Society clerical help.

**NEW COUNCIL . . .** New State Subscriber Advisory Council of Blue Cross/Blue Shield met for first time in March.

**REPLACEMENT . . .** E. B. Mathiasen, M.D., Council Bluffs, has been selected to succeed I. J. Hanssmann, M.D., Council Bluffs, on Blue Shield Board of Directors.

**RECORD PARTICIPATION...** Better than 700 junior high and senior students from across

Iowa exhibited at the 16th annual Hawkeye Science Fair April 5 and 6 in Des Moines. Top scholarship awards were won by Dean Loven, a Newton senior, and Randy Stalzer, a senior at Garrigan High School in Algona. Fair is sponsored by IMS, Scanlon Medical Foundation, Drake University and DES MOINES REGISTER & TRIBUNE.

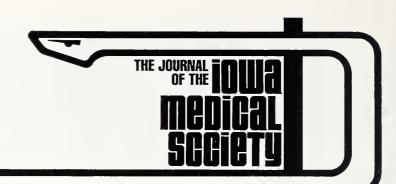
SPORTS PARLEY . . . Nearly 250 coaches, trainers, and physicians attended the April 4 Conference on Medical Aspects of Sports at the Des Moines YMCA. Event was a joint program of the IMS Committee on Sports Medicine and the Iowa High School Athletic Association.

DISTRIBUTE AMA/CPT . . . Copies of the American Medical Association/Current Procedural Terminology are being distributed to member physicians by the IMS field staff. Letter advising of distribution was sent by Society President Flocks in mid-April.

**82 RECOGNIZED...** 82 Iowa physicians were noted as having received the Physician Recognition Award for 1972-73 in a mid-March report issued by the American Medical Association.

FOR REFERENCE . . . IMS Board of Trustees has asked legal counsel to develop resource materials and guidelines to help physicians in devising and considering formal contracts with hospitals. When completed, the materials will be provided to member physicians on request.

**EYE CARE...** Consideration was given in late February meeting of Committee on Eye Care to out-patient eye care coverage under Blue Cross/Blue Shield. BC/BS representatives met with the committee.



VOL. 64 No. 5 MAY, 1974

TABLE OF CONTENTS		SPECIAL DEPARTMENTS				
		President's Page	188			
SCIENTIFIC SECTION		Iowa Medical Miscellany	189			
Total Knee Arthroplasty (Preliminary Report) John H. Kelley, M.D.	197	State Department of Health	191			
tal Knee Arthroplasty (Preliminary Report) John H. Kelley, M.D.  idelines for Choosing a Family Practice Residency Richard Haight, B.A.  eatment of Anxiety Neurosis by Alpha and and Beta Adrenergic Blocking Agents R. Paul Penningroth, M.D., and Charles H. Steinmeyer, Ph.D.		The Question Box	195			
Residency	202	Educationally Speaking	210			
Richard Haight, B.A.	202	In the Public Interest	212			
		About Iowa Physicians	213			
R. Paul Penningroth, M.D., and Charles H. Steinmeyer, Ph.D.	205	Deaths	215			
FULLORIALS		MISCELLANEOUS				
		Continuing Education Courses and Confer-				
Against Minibikes for Children	208	ences	195			
One Shot Medicine	208	Primary Care Preceptorships for Professors	209			
000000000000000000000000000000000000000		OWA MEDICAL COOLETY				

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### State Department of Health

# PRENATAL CHROMOSOME ANALYSIS

Information for the following article was provided by Hans Zellweger, M.D., of the University of Iowa Department of Pediatrics.

The people of Iowa—through the news media—have become increasingly aware of their genetic endowment. Thus, the medical profession has to be prepared to give genetic advice to an increasing number of persons.

A recent development in genetics has to do with prenatal diagnosis of genetic and cytogenetic diseases. Prenatal chromosome analysis (amniocentesis) has become quite important. It is possible to determine the chromosomal make-up of the unborn child as early as the 14th to 17th week of pregnancy. At this time it is possible to take a few milliliters of amniotic fluid from the uterine cavity with minimal risk to mother and fetus, and determine the chromosomal complement of fetal cells suspended in this amniotic fluid. If a prenatal chromosome analysis could be done for every pregnancy, it would be possible to eradicate cytogenetic diseases entirely. (Mongolism or Down's syndrome is probably the best known example of a cytogenetic disease.) This however is technically not possible. Prenatal chromosomal analysis has to be limited, therefore, to so-called "high risk" pregnancies, which amount to about 1,000 to 1,200 pregnancies per year in Iowa. We define a high risk pregnancy as one which carries a risk of over 1% of leading to the birth of a child with a chromosomal abnormality. High risk pregnancies include:

- 1. Women over 40, who have a risk over 1% of having a chromosomally abnormal child.
- 2. Pregnancies where one parent carries a balanced translocation or so-called interchange

heterozygosity. The risk of an abnormal child in this situation varies between 4 and 10% and is in rare instances, even much higher.

- 3. Pregnancies of aneuploid mothers (females with trisomy 21 or trisomy X) and males with the double Y syndrome. The risk for all three of these aneuploidies of having an aneuploid child is considerable.
- 4. Pregnancies where one parent carries a chromosomal mosaicism.
- 5. Pregnancies of mothers who have had a previous child with abnormal chromosomes.

The cytogenetic laboratory in the Pediatric Department at the University of Iowa, in collaboration with the Department of Obstetrics and Gynecology, is set up to perform prenatal chromosomal analyses. The amniocentesis is done as an ambulatory procedure not earlier than the 14th week of gestation. Fetal cells suspended in the amniotic fluid are cultured and their karyotype is analyzed in the usual fashion. Prenatal chromosome analysis has proved to be beneficial in two respects.

A. Since the risk for the above mentioned categories is rarely over and in most instances below 10%, a normal result is obtained in the majority of cases. Thus, the physician is in a position to alleviate the anxieties of a high risk mother during the rest of her pregnancy. Many women have said they felt better after learning the conceptus had a normal karyotype, and some of those considering termination of pregnancy before amniocentesis were glad to be able to continue the pregnancy.

B. On the other hand, it has been estimated that about 80 to 100 abnormal fetuses could be detected in Iowa per year if all high risk women were to have a prenatal chromosome analysis. Among the chromosomal abnormalities would be about 25 mongoloid children. There is no need to stress how many families could be spared the

non-ending grief, sorrow and tragedy of a child with chromosomal abnormalities. Moreover, a fiscal problem is involved as well. James Neel, M.D., professor of genetics at the University of Michigan, recently stated the average lifetime cost of a mongol child is \$180,000. Prevention of only a few mongoloid children, therefore would allow savings of considerable funds, which should

certainly not be overlooked in a time when the cost of health care is skyrocketing.

The State Health Department is in full support of prenatal chromosomal analysis, although the decision regarding amniocentesis is left entirely to the family and the physician. For further information, please contact Dr. Zellweger, (319) 356-2674.

# BACTERIOLOGIC CULTURE SERVICE TO DETECT GONORRHEA

In May of 1973, a bacteriologic culture service to aid physicians in the diagnosis of gonorrhea was initiated in Iowa. At that time, Transgrow media was used exclusively because of its suitability for mailing to the State Hygienic Laboratory. As of January 1974, the bacteriologic culture service was expanded in some locations to include Thayer-Martin media. In these areas (Waterloo, Iowa City, Davenport, Des Moines,

Sioux City and Mason City) a local laboratory processes the specimens. In most of these cities a courier service delivers supplies to participating physicians and in turn transports the inoculated media to the laboratory.

Studies in other states indicate that use of Thayer-Martin gives approximately 10 per cent better "yield" than Transgrow largely due to minimizing the delay in processing the specimens. Both the Transgrow program and the Thayer-Martin programs are operated at no charge to physicians and their patients. Physicians in those

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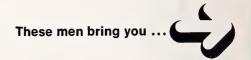


Chris Shibel



Steve Troxel





<sup>\*</sup>For more information on the history of your state, write Professional Services, Marion Laboratories, Inc.

Davenport

areas with a Thayer-Martin program who wish to participate may contact the following persons:

C. B. Preacher, M.D.

Davenport Medical Laboratory

324-0151

Cedar Rapids

Davenport Osteopathic Hospital Laboratory B. G. Mote, D.O.

391-2020

Weland Clinical Laboratories

R. W. Weland, M.D.

363-2966

#### RESULTS OF GONORRHEA CULTURE TESTS ON FEMALES IN IOWA-1973 COMPARED WITH DATA FOR THE UNITED STATES

Source of Test	Number Tested	Number Positive	Per Cent Positive	*United States % Positive
I. Private Physicians	6,823	185	2.7	2.1
2. Health Dept. Family Planning Clinics	330	5	1.5	3.4
3. Public/Private Hospital Outpatient	1,990	61	3.1	4.1
4. Community/Neighborhood Health Centers	677	40	5.9	3.3
5. Private Family Planning Groups	5,569	97	1.7	2.1
6. Group Health Clinic	121	2	1.7	2.6
7. Student Health Centers		26	1.7	2.0
8. Correction or Detention Centers	171	5	2.9	5.4
9. Miscellaneous	. 13	1	7.7	3.2
TOTAL NON-VD CLINICS	17,201	422	2.5	2.9
10. VD Clinics	2,283	407	17.8	19.8
GRAND TOTAL	19,484	829	4.3	4.8

<sup>\*</sup> U. S. data based on 1,833,958 tests done during the period July-September 1973 (M & M Weekly Report Vol. 23 No. 7 February 16, 1974)

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Waterloo/		
Cedar Falls	Black Hawk Medical Laborato	гу
	James Collins M.D.	234-7561

Physicians wishing to use the Transgrow bacteriologic culture service may contact the State Hygienic Laboratory, Medical Laboratories, State University of Iowa, Iowa City, Iowa 52240—(319) 353-5990 and request the estimated number of bottles of media needed for a month.

The table on page 193 summarizes the results of gonorrhea culture tests on females during 1973.

#### Morbidity Report for March, 1974

Disease	March 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties	Disease	March 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties
Amebiasis Chickenpox	2 1385	2 3335	3 7604	Dallas Calhoun, Dubuque, Linn,	Infectious Mononucleosi	s 127	309	270	Johnson, Linn
				Pottawattamie	Influenza-like				
Conjunctivitis	107	208	398	Greene, Linn, Winneshiek	illness	36398	87515	9865	Scattered
Conjunctivitis du	ıe				Influenza,				
to Adenovirus	; I	1		Johnson	lab confirmed		105	91	Johnson, Polk, Woodbur
Coxsackie B <sub>4</sub>	- 1	- 1		Johnson	Meningitis, type				<b>5</b> .
Cytomegalovirus	s 3	16	2	Johnson, Polk	unspecified	2	10	8	Dubuque, Lee
Eaton's agent	5	20	7	Butler, Lee, Mahaska,	Meningitis, bacterial	- 1	3		Crawford
				Mitchell	Meningitis,	'	3		Crawford
Encephalitis, typ	e				H. Influenzae	. 1	2	3	Jasper
unspecified	6	11	7	,	Meningitis,	•	-		ousper .
				Polk, Woodbury	pneumococca	1 1	1	1	Scott
Encephalitis, vir		6	3	Clinton, Page, Cedar	Mixed inf. (Eato				
Enteropathogen					agent & flu)	1	3		Fayette
E. Coli	ı	3	- 1	Johnson	Mumps	475	1149	1982	Black Hawk, Harrison,
Erythema									Linn
infectiosum	59	108	771	Calhoun, Poweshiek, Tama, Warren	Pediculosis	76	155	52	Allamakee, Linn, Muscatine
Gastrointestinal					Pertussis	- 1	4		Wapello
viral inf.	1441	3817	4414	Dubuque, Floyd, Johnson,	Pinworms	8	26		Black Hawk, Polk
				Linn, Van Buren	Pneumonia	141	350	405	Scott
Giardiasis	3	5		Buchanan, Johnson, Polk	Rabies in anima		31	60	Scattered
Gonorrhea	532	1548	1470	Johnson, Linn, Polk,	Rheumatic feve		35	9	Dubuque, Lee, Shelby
				Scott	Ringworm, bod Rubella	y 16 2	70 7	50	Scattered
Guillian-Barre					Rubeola	5	7	118 145	Des Moines, Floyd Des Moines, Floyd, Lee,
syndrome	ı	2		Johnson	Kubeola	5	,	145	Scott
Hepatitis,					Salmonellosis	18	41	24	Scattered
infectious	39	100	89	Linn, Muscatine	Scabies	3	31	5	Johnson
		•		Woodbury	Shigellosis	10	28	55	Cerro Gordo, Johnson,
Hepatitis, serum	ո 8	24	16	Scattered					Linn, Polk
Hepatitis, type	7		_		Streptococcal				
unspecified	7	11	5	Linn, Polk, Pottawattamie, Scott	infections	1464	3996	2714	Jackson, Johnson, Marshall, Polk
Herpes simplex		22	4	Delaware, Johnson, Linn	Syphilis	26	111	88	Scattered
Herpes zoster	6	16	2	Buena Vista, Grundy,	Tuberculosis,				
				Jackson, Johnson	active	4	18	33	Black Hawk, Cerro
Impetigo	57	118	149	Linn					Gordo, Scott



# The Question Box

by L. D. CARAWAY, M.D.

peaker of the Iowa Medical Society House of Delegates since 1969 has been L. D. Caraway, I.D., Amana. Here are comments from Dr. Caravay on the eve of the 1974 Annual Session of he House.

he 1974 Annual Session of the IMS House of lelegates is this month. Do you contemplate a mooth session?

After many sessions as Speaker, one never nticipates a "smooth" session, for at any time ne eloquence of debate can become the wrath of rgument. There do not seem to be as many state sues, i.e., reapportionment of the House, etc., so feel the focus will be on national and governnental issues, e.g., PSRO, price controls, hysicians unions, etc.

s Speaker, what main concerns do you have egarding a meeting of the House?

My main concern is over a "smooth" flow of usiness. I try to assure this by (1) checking the esolutions and reports and preparing for (by iving guidance) any possible parliamentary roblems; and (2) attempting to remain objecve so all issues may be resolved after full and norough discussion and debate on both sides.

The size of the House was increased last year. Will this help or hinder the legislative process?

Increasing the size could make the House more unwieldy and create situations where debate might have to be limited to an adequate and reasonable time. I do feel by increasing the size a more democratic representation has been accomplished.

Is the separation of House sessions from scientific meetings working effectively, or is it too early to tell?

After only two separate sessions it is impossible to make a definitive evaluation. I feel the legislative sessions have been better attended without the several-day gap created by the scientific sessions. Feedback seems to suggest the separate scientific sessions are going to be well accepted.

Do you think House actions really reflect the thinking of Iowa doctors?

I certainly do. The House is a democratic unit in the truest sense. In increasing its size we have approached the one-man-one-vote concept, and we have maintained the voice of even the smallest counties. I constantly emphasize to the delegates they must speak for and represent their constituents. They do this very well.

## Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

oy 6-9 **Cardiology Todoy** oy 9 What's New in Stroke oy 9-11 lowo Eye Association oy 10-11 Iowa Conference on Aging

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June 3-7 Summer Workshop an Alcohalism

June 10-12 American College af Physicians Refresher Course





# Total Knee Arthroplasty (Preliminary Report)

JOHN H. KELLEY, M.D. Des Moines

For Years orthopaedic surgeons have sought a reliable treatment for severe arthritis of the knee. In 1946, Magnusen<sup>1</sup> proposed a technique of knee debridement which was only moderately successful in the treatment of advanced arthritis.

From the standpoint of patient acceptance, fusion of the knee is a very unsatisfactory solution to the painful arthritic knee. In 1960, Walldieus<sup>2</sup> described a hinge knee arthroplasty. Others, including Young<sup>3</sup> and Shiers,<sup>4</sup> offered modifications of this procedure for use in the severely disabled knee joint. Orthopaedists found the infection rate following this procedure unacceptable. Furthermore, the hinges tended to loosen with time.

Coventry,<sup>5</sup> in 1961, proposed osteotomy of the upper tibia for degenerative arthritis of the knee. This operation is applicable where slight varus or valgus deformity exists, and where either the medial or lateral compartment of the knee is relatively normal. The procedure has been very

Geometric total knee replacement is suggested as a reliable treatment in cases of rheumatoid arthritis, osteoarthritis and traumatic arthritis. A satisfactory result has occurred in 25 of 27 knees in the relatively short time period.

successful in our hands for milder cases of degenerative arthritis.

The historic concept of total hip replacement, proposed by Charnley, opened up new possibilities for joint replacement in orthopaedic surgery. Charnley's associate, Gunston,<sup>6</sup> decribed a knee replacement procedure in 1972 based on the principles of the total hip procedure. Since this work, a plethora of modifications of Gunston's total knee procedure have been introduced. The most widely used of these procedures to date employs the implant designed by Coventry, Upshaw, Riley, Finerman and Turner,<sup>7</sup> and named by them the "geometric" knee.

This procedure utilizes a metallic implant which is cemented over the femoral condyles and articulates with a high density polyethylene tibial component which covers the tibial plateau preserving the cruciate ligaments and cemented in place with acrylic. This procedure has been called a total knee procedure, but technically this is not a proper term since the patellofemoral joint is left essentially undisturbed.

Dr. Kelley is in the private practice of Orthopaedic Surgery in Des Moines, Iowa.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF MAY, 1974.



Figure 1. CF (Age 56) Rheumatoid arthritis involving multiple joints. Pre-op total knee replacement, left.

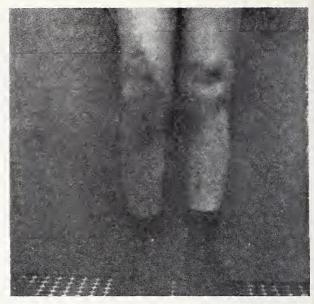


Figure 2. CF Post-op left total knee replacement (negative reversal accounts for apparent discrepancy in laterality).



Figure 3. CF Pre-op both knees standing.

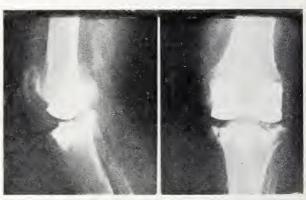


Figure 4. CF Post-op geometric total knee replacement.



Figure 5. MF (Age 59) Rheumatoid arthritis involving knee pre-op.



Figure 6. MF Post-op.

We have been using this procedure (geometric), for 20 months, and have found it to be a reliable method of treating severe degenerative and rheumatoid arthritis of the knee. In one patient, a lateral tibial plateau fracture had healed in mal-union resulting in a painful joint. This patient was treated by a hemi-arthroplasty using the Marmor implant. In another case, we used the polycentric implant designed by Gunston. In all other cases we used the geometric knee joint replacement.

#### **INDICATIONS**

This operation should only be used in severely disabled joints. It should be reserved for older people because the wear characteristics of this joint replacement are not known as yet. While it is known that hip joint replacements are holding up over a prolonged period of time, conditions are enough different in the knee to warrant caution in attempting this procedure in younger people,

except as a last resort. Present or past infection is an absolute contra-indication to this procedure.

#### **PROCEDURE**

Candidates for this operation are admitted to the hospital 3 days prior to surgery for a complete medical workup. This is important because this is a major operation for patients in the older age group. On the fourth postoperative day, the patient is ambulated on crutches and knee motion is started. Patients are kept on crutches for 6 weeks and then are allowed full weight bearing. There is usually a 2 week interval between operations in bilateral cases.

#### RESULTS

The following statistical analysis (Table I), summarizes our first 27 patients. The followup is short, but to date, our patients have tended to improve rather than deteriorate with time. Various

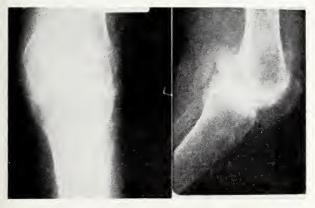


Figure 7. MF Pre-op.



Figure 8. MF Post-op geometric knee.



Figure 9. MJ (Age 81) Osteoarthritis left knee pre-op.



Figure 10. MJ Left knee post-op.

methods of evaluating the results of knee arthroplasty are available. We selected the method proposed by Potter  $et\ al^8$  for this series. See Table II.

#### DISCUSSION

All but two patients under 65 in this series suffered from rheumatoid arthritis. One patient had



Figure II. ME (Age 60) Pre-op old painful lateral tibial plateau lrx. right.



Figure 12. ME Post-op lateral compartment Marmor knee replacement, right knee.

#### TABLE I STATISTICAL ANALYSIS

- 27 Knee joint replacements
- 21 Patients
- 12 Female
- 9 Male

Average age—68
Average followup—8 months

Pre-op Diagnosis

- I Traumatic arthritis
- II Rheumatoid arthritis
- 15 Osteoarthritis

Average evaluation score pre-op-10 points (See Figure 1)

- 18 Rated poor
- 9 Rated fair

Average evaluation score post-op-4 points (See Figure 1)

- 5 Excellent
- 15 Good
- All improved

severe traumatic arthritis following a joint injury, and the other was an overweight patient with severe degenerative arthritis in one knee who was unable to work and support herself. The followup period (average 8 months), is too short for definitive answers about this method of arthroplasty. It will be noted that all patients were rated fair to poor preoperatively, while postoperatively all were rated in the excellent or good category. Early in the series we had some difficulty overcoming flexion deformities, but as we gained experience, we became better able to correct flexion deformity up to 25°. Varus or valgus deformities up to 35° can be corrected using this method, however in some cases, ligamentous instability may limit the effectiveness of the result and in selected cases, a prosthesis similar to the one designed by Herbert and Herbert might be preferred. Patients should be cautioned prior to the procedure that they may lose some degree of flexion beyond 90°, however all of our patients flex satisfactorily to 90°. No patients had an increase in pain following this procedure, but one continues to complain of pain which may be due to a restless leg syndrome. In any event, his pain is different, and far less disabling than the pain experienced in the arthritic knee prior to surgery.

The results reported here are similar to the early results being reported by surgeons using several other similar types of knee joint replacement. The only real difference in many of these operations involves the ease with which the knee replacement prosthesis can be implanted and the

TABLE II
KNEE ARTHROPLASTY EVALUATION

	Demerit	Points
PAIN	-	
None; no limitation of activity		
Occasionally with prolonged walking; no limitat	ion I	
of usual activity	ion	
of usual activity	3	
Pain, sufficient to require narcotics for reli		
marked limitation of activity		
KNEE MOTION		
80 degrees or more	0	
60 to 80 degrees		
30 to 60 degrees		
Less than 30 degrees	6	
FLEXION CONTRACTURE		
None to 5 degrees		
5 to 15 degrees		
30 to 45 degrees		
More than 45 degrees		
VARUS OR VALGUS DEFORMITY		
Less than 10 degrees	0	
10 to 20 degrees		
20 to 30 degrees		
More than 30 degrees	4	
MEDIAL-LATERAL INSTABILITY		
Less than 10 degrees		
More than 20 degrees		
QUADRICEPS POWER		
Normal to good	0	
Good minus to fair plus		
Fair		
Poor		
No motion	6	
SUPPORT		
None Occasionally uses cane	0	
Cane all the time	2	
Crutches		
FINAL RATING		
Excellent	0 to	2
Good		6
Fair Poor		
Poor	H-	+

PAPERS IN ORDER . . . Arthur W. Erskine, M.D., a pioneer and widely known authority in radiology, died in 1952. His correspondence and papers were given to the Iowa Masonic Library in his hometown, Cedar Rapids. These writings

## TABLE III COMPLICATIONS

- 1 Death (cardiac)
- 2 Thrombophlebitis (deep)
- 1 Revisions
- 4 Postoperative cardiac problems
- I Postoperative confusion (chronic brain syndrome)
- 0 Infection
- 0 Hematoma
- O Loosening or failure of prosthesis

degree of correction of deformity obtained. Of the presently available knee replacements, the geometric will probably remain the most widely used.

#### CONCLUSION

Our preliminary results with the geometric total knee replacement suggest that it is a reliable method of treatment in knees severely involved by rheumatoid arthritis, osteoarthritis and traumatic arthritis. It has afforded satisfactory relief of pain in all but 2 of 27 knees. It was effective in reducing varus or valgus deformity in all patients. Mild flexion deformities should be correctable. All patients were improved by the procedure and complications with one exception (death), did not interfere with convalescence or the end result.

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have recently been organized and indexed for ready reference. Dr. Erskine was president of the Radiological Society of North America in 1925 and presided over the Iowa State Medical Society in 1938-39.

# Guidelines for Choosing A Family Practice Residency

RICHARD HAIGHT, B.A. lowa City

Interest in Family Practice has increased sharply among medical students. A University of Iowa senior medical student tells here how he thinks a Family Practice Residency Program should be evaluated by the individual thinking about applying.

IN RECENT YEARS, since the development of Family Practice as a specialty residency,<sup>1</sup> over 150 programs have been approved by the American Board of Family Practice,<sup>2</sup> Very few if any of these residencies have distinguished themselves, one from the other, in their ability to define quality training and substance education. Very few programs have produced three-year graduates that reflect the training capabilities of these new specialty residencies. Furthermore, Family Medicine research has not been developed in any program to the point of attaining prestige for any director or for any program.

Compounding this identification crisis are the intermingled problems of funds and faculty. The upstart specialty of Family Practice is competing with established specialty programs for federal, state, and private dollars, while struggling at the same time to recruit quality faculty from the ranks of "unpublished" Family Physicians.

Such vagueness in the definition of quality training, educational substance, research production, continuing funding, and availability of quality faculty causes the student seeking a quality Family Practice residency to be somewhat confused and bewildered. In an attempt to ascertain salient facts from the program propaganda and identify the quality facets of each program, an

evaluation guide for the Family Practice resident applicant needs to be developed.

The guide should challenge and assist the student as he endeavors to comprehend fully the nature of Family Practice and as he correlates his personal concept of *his* role as a Family Physician with that which is actually emerging. The student must make this evaluation before he chooses Family Practice as a career specialty and certainly before he chooses a program which will mold and direct his thinking for the next 3 years.

The core questions in any guide should make possible a comparison of the essential requirements of Family Practice residencies with those available in the setting or settings which are under consideration.

For example, date of American Board approval reflects not only the age of a training program, but notes further that said program has met the "essentials" as defined by the American Board.3 Thus, the graduates of any such approved program are eligible to stand for the diplomate examination. Additionally, as such programs mature, they will produce Family Physicians who in themselves will reflect the quality of training of the program in which they participated. The aging process should also enhance the sophistication of the program's organizational structure and this will reflect on the director's ability to design and implement a meaningful educational program, as well as the medical and hospital administration's continued support of the Family Practice concept.

There are three classical systems of health care delivery involved in post-doctoral medical education, and each has a somewhat different source of funding. The county hospitals have funds controlled by the local boards of supervisors; university hospitals are controlled and funded by the state legislature through a board of regents, and they also receive federal and private funds. Some of the university-oriented Family Practice residencies are subsidized by a straight

 $Mr.\ Haight$  is a fourth year student in The University of Iowa College of Medicine.

line budget from the state legislature and continued support is at the whim of the granting body. Community hospital residency training programs are supported primarily by patient-generated revenue, but also to a lesser degree by federal and state grants in aid. The resident applicant must attempt to determine the adequacy and availability of funds for both present and future training programs.

The key administrator in any FP residency program is the director, whose philosophical concepts regarding Family Practice pervade the entire program. An in-depth discussion with him or his assistant is mandatory to determine if the philosophy of the resident applicant and the philosophy of the FP program are compatible. The resident should be prepared to interrogate the director or his delegate in considerable depth.

The Model Family Practice Unit (MFPU) has among its primary functions (1) the responsibility to provide the resident with an office in which he can function as the primary physician, and (2) the opportunity to observe and become involved in the routine business functions of a medical office.3 The resident applicant must first define his concept of the role of the Family Physician and determine if the MFPU being observed is compatible with that concept. Classical specialty commitment can be measured to some degree by the logistics of the consultative process. Does the consultation request from Family Practice involve the classical specialist or does the specialty resident conclude the consultation with his recommendation? Referral patterns to the MFPU frequently reflect the attitude of the medical community toward the program as well as the economic stratification of the MFPU patient profile. Referrals from local physicians would suggest the local medical community is sufficiently busy and not threatened by the MFPU, which is a healthy sign. A program should probably not depend upon physician referral for viability as these referrals are usually those who are economically distressed or have other reasons for being incompatible with the referring physician's practice.

Records should be examined to determine their legibility, expression of logical pathways leading to a diagnosis and therapeutic regimen, capability of communication between a multitude of residents, and organization for ease of function and auditing. Charts should be filed in an orderly sequential fashion with family members clustered

together. Problem Oriented Medical Records<sup>4, 5, 6</sup> are used by many programs because this form of recording satisfies most of the preceding criteria. The system of recordkeeping should be designed to store complete data on any and all families in the practice in a simple, efficient, and realistic form. It should allow for multiple-entries and immediate retrieval of basis data pertaining to a single patient, family, or multiple family units. The system should meet both the families' and the physicians' needs by improving the quality of medical care provided.

Additionally, many programs will have a disease index referrable to the entire MFPU patient profile and another disease profile list of the resident's practice. When available, this is an excellent source of material for research in Family Medicine.<sup>7</sup>

Quality programs should have considerable community orientation as evidenced by program/agency interreaction, resident co-ordinated health team conferences, and appropriate utilization of paramedical personnel.

One of the most difficult of all program problems is the conflict which occurs between inpatient and MFPU responsibility. To assign a resident to an inpatient rotation and anticipate that he will spend 30-50% of his time in the MFPU has been solved in different ways by different programs. In reviewing programs, the resident applicant must look for continuity of care; the resident and his patient—is a fundamental training essential.

Other classical specialty resident training programs within the same physical plant may pose a major problem as this arrangement compromises the concept of the Family Practice resident functioning as the primary physician. The classical specialty resident is in training to gain as much experience as is possible, and the Family Practice resident could well be placed in the position of second fiddler all too often.

A guide has been prepared and tested which embodies most of the concepts described in this paper and its use will provide the following benefits to the FP resident applicant:

- 1. Documented evidence of each program's strong and weak points.
- 2. Increased help in comparing the programs visited.
- 3. Assistance in defining Family Practice in much more clear and concise terms.
  - 4. Assessment criteria for those program direc-

tors interviewed to measure their philosophy and basic manner of operation.

The Evaluation Guide for the Family Practice Resident referred to at the outset of this article has been prepared by the author and is available through the Cedar Rapids Medical Education Program, Family Practice Section, 1026 A Avenue, N.E., Cedar Rapids, Iowa 52402. Apreciation is expressed to L. Robert Martin, M.D., Director, Cedar Rapids Family Practice Program, for his assistance with this project. Dr. Martin has recently accepted a new position in California.

The following is a listing of the information requested in the Evaluation Guide for the Family Practice Resident:

Name of Program

City & Hospital

Date of Approval by American Board of Family Practice

Other Residencies/Internships (Specify)

Funding: Hospital County University Federal

Director—Age, Practice Experience, % of Time Spent Administrating, % of Time Spent Teaching, Research Intent, Diplomate

Residents—Total Number by Classes

### I. HOSPITAL

University—Community—County

Number of Beds

% of Occupancy

Administration—Religious, Doctor-owned, Community, Veterans, Military, County

### II. MODEL FAMILY PRACTICE UNIT

Location (Relation to hospital) (Rural/urban setting)

Population (Socio-Economic) % Full-pay, % Part-pay, % Indigent

Number of Families

Number of Encounters per month

Ethnic cross section

Sources of Patients—Self-referral, agency, doctor, emergency room referral

Recordkeeping—POMR, Other, Disease Index, Computerization of data, Audit, Filing System (By family or individual), Dictated, Problem lists, Flow sheets, Audit records

X-ray done by; Laboratory in unit? Procedures: HCT, WBC, Diff., Gram stain, UA, Biochem.

Management—Does resident participate in?

Accounting method: Peg Board, Computer, Other

Billing: From Office, Other

Payments: Prepaid, Medicare, 3rd Party, Govt., Private,

Personnel: Total, Breakdown by classification

Consultation: Resident to resident? Resident to staff?

Referral of indigent patients same as full-pay patients?

Assignment of patients: resident selection, resident selection with director approval, director selection and approval, resident and/or director selection according to disease profile

Supervision: Faculty-Name, Year of Graduation, Specialty,

Certification (Full- and part-time faculty)

Resident teaching?

System to provide appropriate time in Family Practice Center vs inpatient rotation?

Supervision of Family Practice Center admissions?

### III. INSTRUCTION

Faculty (Other than MFPU)—Number of full-time salaried, Number of part-time salaried, Unpaid staff does what percent of teaching

Assignments: Ward, Preceptor, Preceptor office experience, Duration of rotation

Specific rotations:

Surgery—(Objective—to train to perform minor office surgical procedures) Intermediate surgery (Hernia, appendectomy, hemorrhoids, etc.)

Ob-Gyn—No. of Deliveries per month, Supervision of delivery, forceps, C-sections

Medicine—No. of workshops per day, subspecialty electives, CCU rotation?

Pediatrics—Ambulatory care experience? Specialized services?

Psychiatry—Inpatient, Outpatient, Counseling (Marital, Sexual, Adolescent), Group therapy

Other Specialty Electives

Community: Housing, Schools, Recreation, Industries, Support of Program; Medical insurance, Specify salaries and fringe benefits, Service (Seat Work)—Responsibilities, Objectives & Evaluations—Do residents have research projects? How are residents evaluated?

### IV. CONTRACT

Salary, Vacations, etc.

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# Treatment of Anxiety Neurosis by Alpha and Beta Adrenergic Blocking Agents

R. PAUL PENNINGROTH, M.D., and CHARLES H. STEINMEYER, Ph.D.

The salutary effects of propranolol upon anxiety symptoms are reviewed in this case study. Treatment is provided a severe anxiety neurotic by chemotherapy emphasizing both an alpha and beta-adrenergic blocker.

Successes in the treatment of anxiety symptoms with propranolol have generated interest in models of anxiety emphasizing excessive betaadrenergic excitation (Wheatley, 1969; Atsmon et al, 1970; Granville-Grossman and Turner, 1966). However, the fact that some patients are not helped with beta-adrenergic blockades (Tyrer and Larer, 1972) can challenge these models. One logically consistent explanation of both the successes and failures is that anxiety symptoms can result from any of several processes, only one of which is excessive beta-adrenergic excitation. With this model, propranolol should be therapeutic only to the extent to which beta-adrenergic excitation exists in a particular patient. In the general case, therapy of anxiety symptoms might require a beta-adrenergic blockade, measures other than a beta-adrenergic blockade psychotherapy or another drug), or a combination of measures, possibly including a beta-adrenergic blockade.

This case study reports the treatment of a severe anxiety neurotic by chemotherapy emphasizing both an alpha and a beta-adrenergic blocker. The particular patient described served as a subject in a controlled double blind study of the effects of propranolol upon anxiety symptoms (Penningroth and Fieselmann, 1972) and was tested in both placebo and drugged conditions. Within the formal study propranolol dosage of 120 mgs, daily, did not appear to help this person. However, subsequent chemotherapy using higher doses of propranolol (200 or 320 mgs, per day) over a longer period of time (6 months) and combined with trifluoperazine resulted in substantial symptom reduction.

### CASE REPORT

The patient is a 23-year-old single male. His lengthy psychiatric history included severe anxiety. He was first seen as a psychiatric patient at age 14. His referral by a family physician came after he dropped out of eighth grade because of "nervousness," which was elaborated as refusal to go to school, poor academic achievement and worry. The records suggest that these early contacts (attempts to obtain help) were prompted and maintained principally by legal pressures due to his truancy from school. Contacts ceased at age 16 when he legally quit school. In the initial contacts, physical examination revealed no abnormalities and psychological testing revealed a Full Scale IQ Score of 84 on the WISC.

The patient's second application to the mental health center was at the age of 18. He presented voluntarily because of extreme anxiety. A lengthy psychiatric history commences here and follows through to the present. Disability was pronounced and progressive. The patient neither worked nor attended school, suffered anxiety attacks, was unable to leave the house alone, and was financially dependent upon his parents. Over a period of 5 years he visited his family physician about twice a month complaining of serious medical ailments such as cancer and heart disease, without positive findings. He was given individual

Dr. Penningroth is an assistant clinical professor in the Department of Psychiatry at The University of Iowa College of Medicine. Dr. Steinmeyer is a clinical psychologist at the Linn County Psychiatric Clinic in Cedar Rapids.

psychotherapy at various times over this period without apparent improvement.

Following this, subsequent contacts were primarily for medication adjustment. Despite large dosages of a wide spectrum of medications, considerable discomfort was still experienced. Several crises involving emergency phone calls to the psychiatrist and three short hospitalizations occurred over 5 years.

The patient is the youngest in a sibship of two boys. Both parents were married once previously, but both children are of the current marriage. The father is described as an alcoholic who has tended to move frequently among various unskilled labor positions. The mother has had sporadic psychiatric contact throughout the years and had a diagnosed "anxiety reaction." The patient's brother, two years his senior, is described by the patient as having had some kind of "nervous breakdown" while in the Navy. No other details are available. Both parents and the older brother finished nine years of formal education.

The patient's complaints met the criteria for

anxiety neurosis outlined by Pitts et al (1967), and Wheeler, et al (1950).

At the time the formal study was begun (May 11) the patient was being maintained on several medications as described in Table 1. Despite this wide spectrum of medications in relatively high dosages, severe anxiety symptoms persisted. These symptoms are quantified in column 1 of Table 1, in which 17 anxiety related symptoms are rated on a 5-point scale (Pitts *et al*, 1967) ranging from 0 (= not experienced); 1 (= just noticeable); 2 (= definite, but not uncomfortable); 3 (= definite and uncomfortable); 4 (= intolerable).

The second column reflects the symptom severity after 6 days of propranolol, 10 mg, qid, the third after 2 days of placebo and the fourth after 5 days of propranolol, 30 mgs, qid.

A condition of the formal study required participants to discontinue all medications except for the prescribed experimental drugs (propranolol or placebo). In less than 2 weeks, anxiety seemed to increase, and it became clear that the patient could not tolerate this constraint. There-

TABLE I

ANXIETY RELATED SYMPTOMS AND THEIR SEVERITY AT SIX DIFFERENT POINTS IN TIME

Symptom	Date: May II	May 11-17	May 17-19	May 19-23	May 24-Nov. 1!	5 Nov. 15-29
Headache	1	0	0	0	3	0
Dizziness	3	3	3	3	. 3	1
Blurred vision	3	3	3	3	0	0
Dyspnea	4	3	3	4	0	1
Sighing	0	3	3	3	0	0
Tiredness-fatigue	3	3	2	2	1	1
Easy fatiguability	3	3	2	2	1	1
Paresthesias	3	0	3	3	0	0
Depressed moods	3	3	4	4	2	1
Trembling	3	3	3	3	3	2
Shakiness	3	3	4	4	0	0
Weakness	3	3	3	3	1	0
Fears	4	3	4	4	2	1
Initial insomnia	0	0	3	3	0	0
Chest pain	3	0	t	1	3	1
Palpitations	3	3	2	2	1	1
Tension or nervousness	4	4	4	4	3	3
Total Symptom Score	46	40	47	48	23	13
Medication						
Propranolol	0 mgm/day	40 mgm/day	0 mgm/day	120 mgm/day	200 mgm/day	320 mgm/day
Amitriptyline	50 mgs, hs		0			0
Trifluoperazine	5 mg, 6 per day		0			5 mg, 6 per da
Benztropine	I mg, qid & hs		0			l mg, tid
Diazepam	0		0			5 mg, bid
Chlordiazepoxide	25 mg, qid		0			0
Methyprylon	200 mgs, hs		0			200 mgs, hs

fore, from this point on (May 24), propranolol was prescribed in addition to his regular medications described in Table 1.

Relatively little symptom variation was observed among the first 4 measurements, all made within a period of 2 weeks. Those individuals who benefited from propranolol chemotherapy in the formal study showed symptomatic improvement within this period of time. For purposes of the controlled, double blind study, this patient did not appear to respond.

The last two columns reflect symptom severity after a 6 month extended program of chemotherapy, using high doses of propranolol (80 mgs, qam and 40 mgs, noon, dinner and bedtime or 80 mgs, qid), in addition to the other medications described in Table 1. As can be seen, dramatic symptom reduction was noted, with tension and nervousness the only significant anxiety symptoms remaining.

Concomitant with the decrease in formal anxiety symptoms were certain behavioral improvements. The patient reported being able to leave the home alone which he had not been able to do; he reported being told he was looking better by his friends; he reported playing golf, which he hadn't done in four years; and he admitted to significant symptom relief. There has also been a reduction in visits to his family physician with complaints of serious medical diseases to about one visit a month.

### DISCUSSION

This patient experienced significant reduction in his anxiety level only when taking high levels of both a phenothiazine and propranolol. Within the past 6 months he has discontinued either drug on his own for periods up to 24 hours and has noted an increase of anxiety. Removal of either drug causes a significant increase of anxiety symptoms. As this patient did report improvement over a 6 month period in this dosage range without significant side effects (i.e. congestive heart failure), it was elected to make a trial of propranolol at twice the maximum recommended dosage, 80 mg, qid. At this dosage there was a further significant decrease in the level of anxiety.

Our hypothesis is that an anxiety neurosis is caused by overstimulation of some division or combination of divisions of the autonomic nervous system. The autonomic nervous system is divided into the parasympathetic and sympathetic divisions the latter being further subdivided into alpha adrenergic and beta adrenergic receptors. Stimulation upon any part (hypothalamus, parasympathetic division, alpha and beta adrenergic sympathetic division) may produce anxiety symptoms. Anxiety patterns in individual cases result from hyperactivity of the alpha or beta adrenergic sympathetic, the parasympathetic or a combination of these divisions. Effective reduction of severe anxiety may be achieved by blockade of the specific endogenous transmitter at the postsynaptic receptors involved.

To test this, a diagnostic procedure is needed to identify the specific component of the autonomic nervous system affected. Perhaps some combination of behavioral and physiological measurements could be developed. Following this, a formal study relating specific treatment effects to disorders of specific autonomic nervous system components would provide the empirical test of our hypothesis.

Although the therapeutic effects of trifluoperazine are usually interpreted by its mode of action on the central nervous system, we believe in this particular patient that its alpha adrenergic blocking properties contributed to the reduction of anxiety related symptoms.

Other centrally acting drugs (such as amitriptyline), which have only minor alpha adrenergic blocking properties have contributed little reduction of anxiety related symptoms. We believe the significant anxiety reduction demonstrated in this patient is the result of the combined alpha adrenergic blockade by trifluoperazine and beta adrenergic blockade by propranolol.

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M. E. ALBERTS, M.D., Scientific Editor

### AGAINST MINIBIKES FOR CHILDREN

Your editor feels a news release from the American Academy of Pediatrics is worth repetition in its entire form, for the information of physicians in their dual role as parents and advisors to other patients. The following is the complete news release:

The American Academy of Pediatrics Joint Committee on Physical Fitness, Recreation and Sports Medicine has urged parents to "hold firm in their refusal to allow their children the inescapable risk-taking involved in owning and/or operating a minibike."

In a statement on minibike safety, the Joint Committee said, "The trend toward allowing underage children to operate minibikes should be deplored and condemned. This would be indicated on general principles even if the minibike were a quasi-safe vehicle, which it most emphatically is not."

The statement said minibikes are particularly dangerous because of: poor handling due to a

short wheelbase and small tires; insufficient acceleration; inadequate brakes; small size, which decreases visibility; and inadequate protection of drivers against collision.

The Joint Committee said that an estimated two million minibikes are in operation in the United States, most of them driven by children 10-14 years of age.

The Bureau of Product Safety has estimated that there were 75,000 minibike injuries during 1973. Overall, approximately 6,000 children under 14 lose their lives annually in motor vehicle accidents of all types.

The Joint Committee's statement concluded: "We recommend that state legislatures outlaw the operation of any motor vehicle by a person who does not have a full operator's license for which he has qualified by an approved driver training program. We call on the manufacturers of minibikes to cease and desist from the exploitation of children implicit in the promotion of minibikes to parents of children below the age of driver's licensure."—M.E.A.

### ONE SHOT MEDICINE

Undoubtedly, antibiotics are among the most misused of all drugs. Many antibiotics are available. They are valuable and life-saving when used properly. Unwise or unjustified use may result in disaster. Serious errors of commission occur when antibiotics are used for diseases which are known to be resistant to such agents. Conversely, it is an error of omission to withhold or inadequately prescribe the proper antibiotic for a given serious illness such as acute purulent meningitis. This

may be either by failure to diagnose the illness or misunderstanding of the correct therapeutic approach.

It is my impression that one of the most serious abuses of antibiotics is the use of a single injection of either lincomycin or tetracycline for a non-specific upper respiratory infection. Too often one injection of antibiotic is given without further diagnostic follow up or a continuation of the antibiotic by oral administration or subsequent regular injections. The biologic half-life of lincomycin after administration (oral, intravenous or intramuscular) is  $5.4^{\pm 1}$  hours. The therapeutic

blood level then falls and certainly after 12-18 hours is ineffective. That is not long enough for eradication of the infection.

If the antibiotic is truly indicated initially (and often this does not seem to be the case) it would seem a serious act to deny the patient completely adequate therapy. Further, if the injection is not indicated but is given only through therapeutic ignorance, or for pecuniary return to the phy-

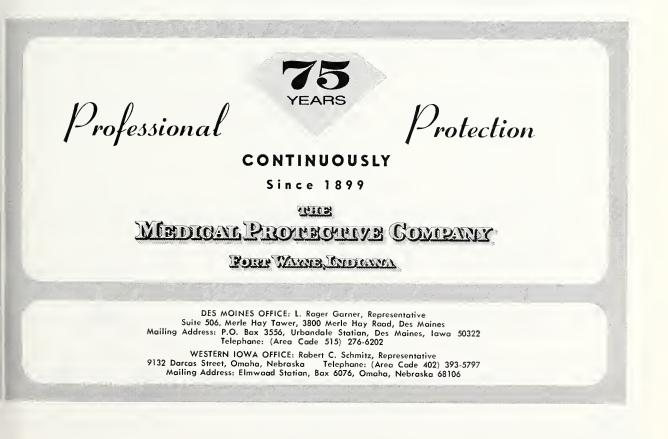
sician, or because the patient, "wanted a shot for a cold," a serious error of commission is committed. Such an act constitutes poor medical practice. If an injection of lincomycin or tetracycline is truly indicated—one shot is not enough. Follow up is required for an adequate period of time with additional injections or oral administration. The patient deserves the best possible treatment.—M.E.A.

# PRIMARY CARE PRECEPTORSHIPS FOR PROFESSORS

The College of Medicine is pleased to announce a new program wherein faculty members from a wide variety of departments will spend three days working alongside a primary care practitioner. Objective of the program will be to provide the professor further insight into the nature, benefits and problems of such practice, to better prepare him to counsel and support students as they consider possible careers in primary care. The professor will have opportunity to engage in "rap sessions" with other professional colleagues in

the local area. Subsequently, the primary care practitioner will visit the medical center for a few days of individualized traineeship.

The sites of the professorial preceptorships will be chosen mainly from the offices now offering experiences in the senior year elective preceptorship in primary care. The arrangements will be made by the Office of Continuing Medical Education at the College of Medicine which is directed by Richard M. Caplan, M.D. Cost of the program will be offset in part from a grant by The National Fund for Medical Education, a private foundation that seeks to support innovative programs in medical education.



# **Educationally Speaking**

by RICHARD M. CAPLAN, M.D.

### PUT ME OUT OF BUSINESS?

At a recent meeting to plan an ambitious educational program to take place in an Iowa community, one of my hosts said, "Gee, if you develop these activities all over the state, nobody would come to attend the courses and programs at Iowa City anymore. You'd be put out of business." Let me tell you why I think I'll be "in business" for quite a while.

First, although local programs carefully planned in response to local needs should be especially fruitful for learning, they will never provide the same sense of "total immersion" in the educational process that can be offered at the Medical Center. The trip away develops a psychological set for receptivity. The emergency calls

 $\mbox{Dr.}$  Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine,

are indeed at a minimum. And there is an opportunity to include a much-needed element of relaxation.

Second, even if all go-to-Iowa-City-to-sit-down and-listen programs were to stop, the opportunity for individually tailored, brief in-residence experiences at the health science center, which expect to see grow in number, can *only* be accomplished at the health science center.

Third, all this educational "competition" at the local level is not going to develop just by itself It will require local initiative, to be sure, bu combined with it must be a large measure of educational consultative service plus access to medical center personnel.

So I genuinely hope that my personal activity and impact will grow increasingly in Iowa communities where educational need exists. I forese this activity greatly augmenting, always challenging and exciting. And I hope it may prove so fo you, too. Let's work at it together!

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for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be crossindexed in a useful way.

### Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

# Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess

and indicate instances where a meaningful difference between drugs is pertinent.

## Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

should in no way imply control over the practitioner's prerogatives.

### Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should not be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than pro-

duce another book, it makes muchmore sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

# Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level — a most dangerous trend for medicine.

# New Compendium — A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per

cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, not the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

### Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005



# FOUNDATION FOR MEDICAL CARE AND PSRO

THE FOLLOWING 10 facts may help readers understand the current status and potential role of the Iowa Foundation for Medical Care in the federally-imposed Professional Standards Review Organization (PSRO) program.

- 1. The PSRO program was established by 1972 passage of Public Law 92-603. PSRO is intended to be organized, administered and controlled by local physicians. It must evaluate the necessity and quality of medical care delivered to individuals in the Medicare, Medicaid and Maternal and Child Health programs.
- 2. The Iowa Foundation for Medical Care (IFMC) was created in 1971 by Iowa physicians to assure the public of the profession's commitment to four aspects of medical care, namely, that it's (a) good, (b) provided in appropriate amounts, (c) available within reasonable distance, and (d) cost is fair.
- 3. The IFMC is not now the PSRO in Iowa. The Foundation has been asked by the Iowa Medical Society to represent the profession in considering the position of Iowa medicine with respect to PSRO. No less than 15 health-related organizations in Iowa have encouraged the Foundation to seek PSRO designation.
- 4. A first step required of the Department of Health, Education and Welfare is PSRO area designation. These geographic designations were made final in April with Iowa included among 31 states named as single statewide PSROs. HEW must contact qualified physician organizations in these areas to see if they wish to be PSROs.
- 5. Until January 1, 1976, only a non-profit, professional body representing most physicians in a given area can qualify as a PSRO. If such an organization fails to apply by 1976, HEW can pick any agency it thinks has the competence.
- 6. HEW must inform all M.D.'s and D.O.'s in the area of its PSRO selection. If more than 10% of the physicians say the organization is not representative, HEW must poll all doctors in the area. If more than 50% of the poll respondents

- say the designated body is not representative, the Secretary may not contract with that organization.
- 7. After January 1, 1976, the preceding provision presumably becomes inoperative because PSRO responsibility then may be entrusted by HEW to the organization of its choosing. This assumes no qualified medical unit has sought and achieved PSRO designation by that date.
- 8. The physician officers and administrative staff of the Foundation have examined Public Law 92-603 extensively, particularly the potential role of the Foundation as the Iowa PSRO. Under the law, the PSRO is responsible for reviewing professional activity of physicians and other health care providers. A PSRO must assure (1) the medical necessity of care, and (2) the quality of that care. These requirements are consistent with the founding commitment of the Foundation. In its ever-increasing peer review activity, the Foundation has stressed local participation. Foundation district peer review committees are providing guidance and support in local utilization review programs and expect to continue these efforts.
- 9. The Foundation is dedicated to being responsive to the physicians of Iowa (and in turn to the public) with respect to (1) its ongoing peer review efforts, and (2) its potential involvement in PSRO. Its officers are fully aware of the complexity, the responsibility and the opportunity which confronts the medical profession.
- 10. The Foundation Board of Directors has urged Iowa physicians to use the expertise and resources of the Foundation, the Iowa Medical Society and the American Medical Association in following PSRO developments. The repeal of the PSRO law has been advocated and is being pursued by some organizations about the country. This possibility deserves consideration. However, until any such action is taken and because PSRO is the law of the land, the Iowa Foundation is attempting to act responsibly to prepare for it.

# IN THE PUBLIC INTEREST

# About IOWA Physicians

Dr. R. A. Selo, Council Bluffs, has been named president of Council Bluffs' Mercy Hospital medical staff. . . . Dr. Charles B. Carignan is new family practitioner at the Spirit Lake Medical Center. Dr. Carignan received the M.D. degree at Creighton University School of Medicine and interned at Nebraska Methodist Hospital in Omaha. For the past 15 years he has been engaged in the family practice of medicine at Broken Bow, Nebraska. Dr. Carignan is a diplomate of the American Board of Family Practice and an aviation medical examiner of the Federal Aviation Agency. . . . Dr. B. A. DeLeon, medical director for West Central Iowa Mental Health Center in Adel, is conducting a course in drug and alcohol addiction at Clarinda Campus of Iowa Western Community College. . . . Dr. Gerald Miller, Clarinda, will serve as co-chairman of 1974 Heart Fund Drive in Page County. . . . Dr. C. P. Addison, Waterloo, attended a recent three-day postgraduate seminar at the Ochsner Clinic in New Orleans, La. The seminar was programmed especially for general surgeons. Dr. Addison is chief of staff at St. Francis Hospital in Waterloo and president-elect of Iowa Academy of Surgeons. . . . Drs. J. A. Bullard and Leonard Lamberty, Decorah physicians, were guest speakers following film presentation at two Decorah High Schools on "Cancer Detection for Females." The program was sponsored by Northeast Iowa Area One School, Adult Education; American Cancer Society; Decorah Community Schools and North Winneshiek Community Schools.

Dr. Herbert Buchsbaum, associate professor of obstetrics and gynecology at U. of I. College of Medicine, was guest speaker at recent meeting of Wapello County Medical Society. Dr. Buchsbaum presented a program on "Management of Gynecologic Malignancy." . . . Dr. George Schnug, Dows, was granted life membership in Iowa Academy of Family Physicians at recent IAFP

board meeting. Dr. Schnug has served as member of the Academy since 1951. . . . Dr. Paul M. Seebolm, associate dean, U. of I. College of Medicine, has received Distinguished Service Award from the American Academy of Allergy. The award, the Academy's highest honor, was presented at recent AAA annual meeting in Bal Harbour, Florida. Dr. Seebohm was cited for outstanding program in allergy developed at U. of I. College of Medicine and significant contributions in organizational leadership and administrative capabilities. . . . Dr. R. B. Dunker, Mason City, was guest speaker at the January meeting of the Wright County Medical Society. Dr. Dunker spoke on "Newer OB Techniques."

Dr. Don Bock, Fort Dodge, and Dr. Dale Harding, Eagle Grove, are conducting courses in the Continuing Health Occupations Education Department of the Adult Education Division of Iowa Central Community College. Dr. Bock's class is on Recent Developments in Measuring Cardiac Function. Dr. Harding's subject is Coronary Disease 1974. . . . Dr. C. F. Brummitt, Centerville, was recently honored by employees of Golden Age Manor for his five years of service as house physician at the Manor. . . . Dr. Craig D. Ellyson, Waterloo; Dr. John K. MacGregor, Mason City, Dr. Joseph Veverka, Prairie City; Dr. Ralph L. Wicks, Boone, and Dr. James Young, New Hampton, were guest faculty at recent U. of I. College of Medicine Refresher Course for Family Physicians.

**Dr. Robert Donlin**, medical director of Powell III Alcoholic Treatment Unit in Des Moines, moderated a recent public forum on alcoholism at Iowa Methodist Hospital School of Nursing Auditorium. . . . **Dr. Patricia Ehrich**, Grundy Center, participated in a panel disucssion on "Who Says It's a Man's Job," at recent meeting of the community's Business and Professional

Women's Club. . . . Dr. Eugene Wiemers has resigned as superintendent of State Mental Health Institute in Cherokee. Dr. Wiemers will remain active in the facility as a member of the clinical staff.

Drs. James Carr and Joseph D. Brown, New Hampton, were program participants in a Continuing Health Science Education Seminar entitled, "Diabetes-What's New-What's Old," at St. Joseph Community Hospital in New Hampton. . . . Dr. Charles N. Hyatt, Anamosa, has closed his medical practice in Onslow and relocated in Elkader. . . . Dr. and Mrs. William A. Seidler, Jr., and Dr. and Mrs. Robert Heise, Story City, attended a recent symposium on infectious disease in Bermuda sponsored by Mc-Kesson Laboratories. . . . Dr. Stephen VanHouten, radiologist, and Bernie Topf, Chief X-ray technician, at Mary Greeley Hospital in Ames, gave a team presentation on "Nuclear Medicine," at February scientific session of Wright County Medical Society.

Dr. R. D. Brundage, president, Cherokee Mental Health Institute medical staff, has announced appointment of the following physicians to the consulting staff: Drs. T. M. Gary, M. D. Hayden, G. E. Michel, D. J. Sheehan, D. C. Koser, J. N. Harten, R. J. Martin, H. J. Fishman, all of Cherokee; and Dr. R. D. Berge, Aurelia, and Dr. P. D. Boone, Paullina. The addition of local physicians will enable MHI staff to share consultation, training programs and better coordinate their services. . . . At recent annual meeting of American Psychiatric Association in Detroit, Dr. Marcus B. Emmons, Clinton, was awarded the gold commemorative medallion and life fellowship for his 30 years' service. Dr. Emmons has practiced psychiatry in Clinton since 1946. He is a diplomate of American Board of Psychiatry and Neurology, past president of Iowa Psychiatric Society, Clinton County Medical Society, staff of St. Joseph Mercy Hospital; fellow of American Academy of Forensic Science, Life member of Academy of Religion and Health and has served for many years on the Iowa Medical Society Committee on Psychiatric Care. . . . Dr. and Mrs. Dale L. Christensen, Lake City, attended a recent post-graduate medical education session at University of Missouri-Kansas City. The program entitled, "The Long Weekend," included a medical program for the physician and a liberal arts program for the wife. . . . Dr. Louis Fingerman, Des Moines, was guest speaker at recent meeting of Central Iowa Unit of Iowa Diabetes Association. Dr. Fingerman spoke on "Ocular Complications of Diabetes Mellitus."

Dr. Carl O. Lester, Marshalltown orthopedic surgeon, was guest speaker at recent meeting of Mothers of Twins Club in Marshalltown, Dr. Lester's topic "Twins and Twinning." . . . Dr. Timothy Kling, Iowa City, was guest speaker at organizational meeting for Waterloo Chapter of the Iowa Guild for Infant Survival. . . . Dr. Truce Ordona, Director of Administrative Service, Scott Community Mental Health Clinic, discussed emotional and physical aspects of child abuse at Estherville Seminar sponsored by Iowa Lakes Community College. . . . Dr. B. A. De-Leon, medical director and psychiatrist for West Central Iowa Mental Health in Adel, is conduct ing a course in drug and alcohol addiction at Iowa Western Community College during spring quar ter. The course is a study of alcohol, therapeutic and illegally used drugs and their effects on be havior.

Dr. Homer E. Wichern, Des Moines, has beer elected a regional delegate to the House of Dele gates of the American Hospital Association. The Regional Delegate is a special category created last year to give physicians and hospital trustee a greater role in the association's policy-making process. . . . Dr. D. M. Tan Creti, Denison, was recently elected chairman of Crawford County Board of Health.

Dr. Robert Corry, director of Transplantation Service at University Hospitals, was guest speak er at recent meeting of Linn County Medical Sc ciety. Dr. Corry's topic "Transplantation in Iowa."... Dr. Reginald R. Cooper, professor and head of Orthopedic Department at U. of I. Col lege of Medicine, is new president of the National Orthopedic Research Society. . . . Dr. Ralph I Wicks, Boone, recently met with officials an physicians in Webster City to discuss physicial recruitment activities in Hamilton County. Di Wicks also inspected Hamilton County Hospita facilities. . . . Three Conrad physicians, Dr. R. K. Patterson, D. R. Kruschwitz and G. I Button, of the Conrad Medical Clinic, wer named "Bosses of the Year at annual Boss Nigh of American Business Women's Association i Marshalltown.... Dr. Frank Harper, Fort Madison, has been named administrator of Lee County Department of Health.

... New president of Clinton County Medical Society is Dr. D. R. Schumacher, vice-president, Dr. Richard Krieter; and secretary-treasurer, Dr. Dale Wulf.

### **DEATHS**

Dr. Robert J. Smith, 47, of Stacyville, died February 17 at his home of an apparent heart attack. Dr. Smith received the M.D. degree at U. of I. College of Medicine in 1953, served his internship at Broadlawns Hospital in Des Moines, and had practiced family medicine in Stacyville for 20 years. He was associated with Dr. T. E. Blong until Dr. Blong's retirement two years ago. Dr. Smith was a member of Iowa Medical Society and American Medical Association.

**Dr. John O. Eiel**, 73, died at his home in Osage February 23. A 1923 graduate of U. of I. College of Medicine, Dr. Eiel was active in establishing

the Mitchell County Memorial Hospital and served as its first chief of staff. He was a member of World Medical Association, American Academy of Family Physicians, and life member of Mitchell County Medical Society, Iowa Medical Society, and American Medical Association.

Dr. Leo B. Sedlacck, 77, Cedar Rapids physician for 30 years, died March 11 in Pullman, Washington. A graduate of U. of I. College of Medicine, Dr. Sedlacek was one of the founders of the Linn County Mental Health Center, the Linn County Mental Health Association, and the Citizens Committee on Alcoholism and Drug Abuse. Dr. Sedlacek was the first recipient, in 1969, of the Leo B. Sedlacek Alcoholism Foundation Award, named in his honor at the U. of I. In 1971, he received the IMS Merit Award, and was the first recipient of the Linn County Medical Society appreciation award. He was a member of the Linn County Medical Society, Iowa Medical Society, American Medical Association and an honorary member of St. Luke's and Mercy Hospitals.

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# LIST YOUR WANTS

No charge is made for the ads of members, wives of deceased members of the Iowa Medical Society or physicians seeking Iowa locations; for others the cost is \$1.00 per line, \$5.00 minimum per insertion. Copy for ad must be received by the seventh of the month for the following issue. Send to JOURNAL OF THE IOWA MEDICAL SOCIETY, 1001 Grand, West Des Moines 50265.

OFFICE SPACE—834 square feet available for an M.D. due to death of doctor. Also, 470 square feet, Contact C. E. Emerson, Manager, Des Moines Medical Center, 1057 Fifth Street, Des Moines, Iowa 50314. Telephone: 244-2664.

FAMILY PRACTICE—Opportunity for physician having residency or practice experience with the largest prepaid group in the Midwest. Our small family practice section is planning expansion into a fourth suburban clinic. Interested physicians will participate in our development. Ideal metropolitan setting with all services and opportunities. Competitive salary and liberal benefits. Contact J. Gutenkauf, M.D., Group Health Plan, 2500 Como Ave., St. Paul, Minu. 55108 (612) 645-5851.

INTERNIST—Minneapolis-Saint Paul. Midwest's leading prepaid group, democratically managed, offers high standards, rapid advancement, no investment. Generous vacation and conference leave, fully paid insurance and retirement. Teaching and professional pursuits encouraged. Ronald W. Ellis, M.D., 2500 Como Avenue, Saint Paul, Minnesota 55108.

OBSTETRICIAN WANTED to associate with rapidly growing four-physician OB-GYN department in prepaid multi-specialty group. Generous compensation, vacation and conference leave, fully paid insurance and retirement. Teaching and professional pursuits encouraged. Contact M. M. Aksoy, M.D., FACOG (612) 645-5851, 2500 Como Avenue, Saint Paul, Minnesota 55108.

GENERAL PRACTITIONERS WANTED in town of 7,000; serves area of 15,000; 4 M.D.'s presently in town. Solo or group practice available. Contact Chairman, Medical Recruitment, St. Joseph's Mercy Hospital, Centerville, Iowa 52544.

PHYSICIAN WANTED—Manson, Iowa, population 2,400. We have office all set up with a full line of equipment including X-ray and latest laboratory apparatus. Will support our doctor 100%. Within 10 miles of Twin Lakes and 100 miles from Iowa Great Lakes. Within 15 miles of Fort Dodgc hospitals where all specialties are represented and quick referral available. Staff privileges available. Any reasonable arrangement can be made on equipment, and office rent will be free for one year. Arrangements will be made to reimburse any physician for cost of travel to our town by him and his family. We want a doctor! Write or call Larry E. Sanburg, 1010 Main, Manson, Iowa 50563.

GENERAL PRACTITIONER NEEDED: Practice with complete freedom of action in a rural atmosphere? Office next to pharmacy, ready for occupancy, no unseen strings. Moville, Iowa, 15 miles east of Sioux City offers just such a chance. Contact Moville Community Development Association, Inc., Moville, Iowa.

IMMEDIATE OPENING for Ob-Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

WANTED—FAMILY PRACTITIONER to associate with clinic group in northcentral Iowa. Community of 32,000. Excellent salary with planned time off. Replies confidential. Write No. 1497, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

FAMILY PRACTITIONER—WANTED TO JOIN SMALL PROGRESSIVE GROUP serving beautiful Mille Lacs Lake area, only eighty miles north of Minneapolis; modern clinic and JCAH 73-bed hospital and ECF; excellent income; group support; two out of three weekends off; away from the madding crowd; yet not too far away; good schools; clean, uncrowded environment; lakes to live on; unfettered living; we need you. Contact Dr. Dennis R. Jacobson, 612-532-3113 (clinic), 612-532-3628 (home), or Marshall Engstrom, Hospital Administrator, 612-532-3154 (office), 612-532-3693 (home).

PRACTICE FOR SALE—Office and hospital practice. Open staff, city hospital with radiologist and surgeon. 8-room office with EKG, X-ray, physiotherapy. Golf, fishing, swimming, tennis near. Patients appreciate and pay for scientific care. Address your inquiry to No. 1500, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

WANTED—FAMILY PRACTITIONER to join 8-man multispecialty group. Excellent clinic and hospital facilities. Unusually progressive small community in which to live and raise a family. Excellent salary and benefits, partnership in twelve months. liberal vacation and meeting time. Contact Richard A. Callis, Administrator, McCrary-Rost Clinic, Lake City, Iowa 51449. Telephone 712-464-3194.

GENERAL PRACTITIONERS NEEDED to assist in the development of an Acute Care Department in 34-man Group Excellent starting salary and fringe benefits, Contact Dr. D. M. Wall, McFarland Clinic, Ames, Iowa 50010. Phone 515/232-4530.

BARGAIN in physician's complete office furniture, including reception room, examining rooms, Hamilton tables, etc. Ideal for someone starting practice, I am retiring July 1. Address your in quiry to No. 1501, Journal of the Iowa Medical Society, 100 Grand Avenue, West Des Moines, Iowa 50265.

FAMILY PRACTITIONER NEEDED—Twenty-five year activand well established practice. Present physician forced into retirement due to health. Pleasant smog-free rural community serving a large livestock and farming trade area in northeas Nebraska. Three light industries within twenty mile radius Small hospital ideal for emergency and maternity care. 50-behand expanding nursing home, Forty minutes of non-metropoli and deving two major fully equipped hospitals. Abundan opportunities for "the good life" including pheasant hunting swimming, golf, tennis, and horseback riding. Call or writ E. W. Carlson, M.D.; or Lloyd Welburn, R.P., Newman Grove Nebraska 68758.

### INDEX TO ADVERTISERS

Burroughs Wellcome 210
Flint Laboratories
Li'lly, Eli, & Company
McNeil Laboratories202Marion Laboratories192-19Medical Protective Company20Milwaukee Sanitarium Foundation21
Pharmaceutical Manufacturers Association 210D, 21 Prouty Company
Robins, A. H., & Co
Searle, G. D., & Co

# espond to one

According to her major ptoms, she is a psychoneuc patient with severe iety. But according to the cription she gives of her ings, part of the problem sound like depression. s is because her problem, ough primarily one of exive anxiety, is often accomied by depressive symptomogy. Valium (diazepam) provide relief for both—as excessive anxiety is reed, the depressive symps associated with it are also n relieved.

There are other advansin using Valium for the agement of psychoneuranxiety with secondary ressive symptoms: the chotherapeutic effect of um is pronounced and d. This means that imprement is usually apparent a patient within a few grather than in a week or

two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An h.s. dose added to the b.i.d. or t.i.d. treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, et al: Dis Nerv Syst 30:675-679, Oct 1969. 2. Hollister LE, et al: Arch Gen Psychiatry 24:273-278, Mar 1971.

3. Claghorn J: Psychosomatics 11:438-441, Sept-Oct 1970.



# Valum<sup>®</sup> (diazepam) 2-mg, 5-mg, 10-mg tablets

2-mg, 5-mg, 10-mg tablets

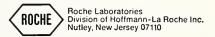
in psychoneurotic anxiety states with associated depressive symptoms

eillance because of their predisposito habituation and dependence. In nancy, lactation or women of childng age, weigh potential benefit ast possible hazard.

autions: If combined with other psyopics or anticonvulsants, consider fully pharmacology of agents emad; drugs such as phenothiazines, ptics, barbiturates, MAO inhibitors other antidepressants may potentiate tion. Usual precautions indicated in nts severely depressed, or with latent ession, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

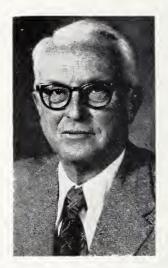




At the close of the meeting of the House of Delegates on May 13, it was an honor for me to accept responsibility for the IMS presidency for the coming year. The gavel was offered by Dr. Flocks.

Over the past few years it has been my good fortune to have met with many physicians from within and outside our state. These contacts and the resulting friendships are among the most rewarding of the fringe benefits which accrue from Society involvement.

I have known Dr. Flocks for a long time. In recent years, however, I have become well acquainted with him and have come to know and appreciate first hand those personal qualities which make him a great man. Numerous honors have been bestowed upon him, in fact, just about all



that one in his capacity could acquire. But the one honor he enjoys most is that his former students and associates are giving excellent medical service to their patients. This is because he taught them to be compassionate physicians at the same time they learned the best of scientific medical and surgical methods.

His influence will continue as he assumes another role or title. Vigor and devotion have characterized his life of teaching. He represented the Society this past year with the same wholehearted devotion. We wish you well, Rubin.

Sincerely,

Ralph L. Wicks

Ralph L. Wicks, President

# IOWA Medical Miscellany

HONOREES... S. P. Leinbach, M.D., Belmond, on May 12 became only the second Iowa physician to receive the IMS Distinguished Service Award. Dr. Leinbach has served as president and board chairman of both the IMS and Blue Shield. 1974 IMS Merit Award was presented to J. H. Sunderbruch, M.D., Davenport. Ben T. Whitaker Inter-State Postgraduate Teaching Award was given to J. M. Bruner, M.D., Des Moines. John F. Sanford Award for distinguished service by a lay person was presented to Miss Gladys Manning, assistant vice-president, Iowa State Bank, Iowa City, for her work in connection with the Scanlon Foundation loan program.

JUDICIAL COUNCIL . . . New members of the IMS Judicial Council are W. V. Wulfekuhler, M.D., Mason City; R. L. Kent, M.D., Fort Madison; S. A. Smith, M.D., Oskaloosa, and J. D. Kimball, M.D., Osceola. J. E. Tyrrell, M.D., Manchester, succeeds E. E. Gamet, M.D., Lamoni, as Council chairman; Hormoz Rassekh, M.D., Council Bluffs, is new Council secretary.

BLUE SHIELD DELEGATES . . . C. W. Seibert, M.D., Waterloo, and J. D. Ver Steeg, M.D., Des Moines, were elected Blue Shield liaison delegates to the IMS.

IMS OFFICERS . . . R. L. Wicks, M.D., Boone, was installed May 13 as Society's 1974-75 president. Elected or re-elected to IMS offices May 13 were V. L. Schlaser, M.D., Des Moines, president-elect; T. E. Kiernan, M.D., Newton, vice-president; J. F. Bishop, M.D., trustee; J. H. Kelley, M.D., Des Moines, trustee; L. D. Caraway, M.D., Amana, speaker; and R. D. Whinery, M.D., Iowa City, vice-speaker. W. R. Bliss, M.D., Ames, is Board appointee to replace Dr. Schlaser as secretary.

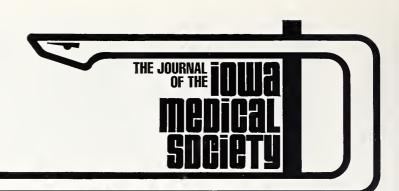
AMA DELEGATES . . . L. W. Swanson, M.D., Mason City, was re-elected an AMA delegate. Newly-elected as AMA delegate is Erling Larson, Jr., M.D., Davenport. Dr. Larson will succeed Herman Smith, M.D., January 1, 1975. Hold-over delegate is C. E. Radcliffe, M.D., Iowa City. Alternate AMA delegates are J. R. Anderson, M.D., Boone, J. M. Rhodes, Sr., M.D., Pocahontas, and J. R. Scheibe, M.D., Bloomfield. Dr. Larson continues as alternate delegate to January 1 when Dr. Scheibe assumes this post.

LIFE MEMBERS . . . Accorded IMS Life Memberships May 12 were Ludwig Gittler, M.D., Fairfield, H. C. Bone, M.D., Des Moines, D. H. Kast, M.D., Des Moines, B. F. Kilgore, M.D., Des Moines, and E. A. Vorisek, M.D., formerly of Des Moines.

HOUSE ACTION... Following is a summary of May 13 House actions: (1) endorsed usual, customary and reasonable fee concept; (2) backed Iowa Foundation for Medical Care (IFMC) as body to settle third party payment disputes; (3) asked for Blue Shield release of "usual" fee profiles, customary fee screens or relative value indices to individual physicians and/or county medical societies (to include dollar value assignment in case of RVI), this kind of information is also

to be sought from private insurance companies; (4) affirmed IFMC practice of specialist and generalist participation in peer review; (5) suggested IFMC support individual physicians and hospital medical staffs in devising quality assurance programs that make effective use of lay personnel and physicians; (6) called for continued written and oral communication to explain to physicians the third-party services performed by the Society

(Please turn to page 246)



VOL. 64 No. 6 JUNE, 1974

TABLE OF CONTENTS		SPECIAL DEPARTMENTS				
	President's Page	224				
SCIENTIFIC SECTION		Iowa Medical Miscellany	225			
The Physician and the Alcoholic Harold F. Moessner, M.D., F. William Ben-		The Question Box	227			
nett, M.D., and Chester F. McClure, M.D.	233	In the Public Interest	228			
Jejuno-Ileostomy and Abdominal Lipectomy		State Department of Health	229			
in Treatment of Morbid Obesity E. J. Drew, M.D.	238	Continuing Education Courses and Conferences	246			
The Aging Face Charles J. Krause, M.D., and Stefan Dem-		Educationally Speaking	247			
jen, M.D	242	Medical Assistants	248			
		About Iowa Physicians	252			
EDITORIALS						
Decisions with Satisfying Results	245	MISCELLANEOUS				
Instant Learning	245	Summary of IMS Group Coverages				

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Address all communications to the Editor of the Journal, 1001 Grand, West Des Moines, Iowa 50265.

Postmaster, send form 3579 to the above address.





by F. W. BENNETT, M.D.

Dr. Bennett is chairman of the Iowa Medical Society Committee on Drug Abuse. He is associate director of the Family Practice Residency Program in Cedar Rapids.

The problem of drug addiction seems to have diminished in the past year or so, at least in amount of press exposure. What is your assessment?

Although use of most illicit drugs has decreased, except for marijuana, the problem remains. The greatest reduction is in the use of the hallucinogenics and stimulants while barbiturates and heroin, although declined in use, remain at a moderate level. We do not hear as much about it now as it has lost much of its appeal to the news media.

What are the main concerns of the IMS Committee on Drug Abnse?

The physician's role has changed as the problem of illicit drug abuse is now primarily in the hands of the law enforcement agencies and the drug treatment programs. The community and area drug programs still need the physician's professional expertise, and the patients who are having medical problems related to drug abuse need his medical skill. A main concern of your IMS Drug Abuse Committee is the misuse and abuse of prescription medication.

What programs have been most successful in stemming the drug problem? Is education more effective than punitive action?

No one element is responsible for the decline in drug abuse. There has been a change in the attitudes of the populace, which is the result of many efforts, including educational endeavors ranging from the mere presentation of facts to programs dealing with value clarification. Law enforcement and punishment may contribute some motivation for change, but it is doubtful that by themselves punitive measures produce alterations in behaviour.

What is the single, most important admonition you would give to an Iowa physician in his drug prescribing role?

That each physician scrutinize his personal prescribing habits, particularly relating to the mood modifying drugs. The medical profession must educate the population that chemistry is not necessarily the way to better living. The physician might well consider it a therapeutic triumph to help the emotionally ill patient without having to resort to a psychoactive drug.

▲ Milwaukee Psychiatric Hospital

Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.

▲ Milwaukee Sanitarium

Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.

▲ Dewey Center { Acute detoxification and inpatient treatment for alcoholic dependency, daily schedules, broad supportive services.

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227

# SCANLON FOUNDATION LOANS \$65,113 IN 1973-74

ELP. We call on this word frequently in our lifetimes. From infancy to retirement. When the call is answered, and our problem is resolved, we are relieved, thankful, etc., each in our own way.

The Scanlon Medical Foundation/Iowa Medical Society is one helping organization. It is sponsored, supported and promoted by the medical profession in Iowa.

How does it help?

In the 1973-74 school year, the Foundation aided 43 Iowans who are seeking to become physicians. It helped these medical students by loaning them funds to meet education and living expenses. 1973-74 loans were made in a total amount of \$65,113. Individual loans ranged in amount, depending on need, from \$500 to \$2,000.

The year previous 41 Iowans received loans totalling \$56,055. In total, over the 20-plus years in which the medical student loan program has been active, \$543,319.52 has been provided to deserving Iowans aspiring to become physicians. In all, there have been 310 loan recipients and 162 of these have repaid the borrowings in full.

The Foundation was formed in 1953 as the Iowa State Medical Society Educational Fund. In 1963 the name was changed to Iowa Medical Foundation. In 1968 the present designation was authorized to honor George H. Scanlon, M.D. It was through Dr. Scanlon's efforts that the Foundation was established. Dr. Scanlon was a surgeon in Iowa City.

Formally, the SMF/IMS is a non-profit corporation established to engage in, assist, further, promote and contribute to the support of such charitable, educational and scientific activities and projects as are in general, either directly or indirectly, related to health or medicine.

As reported here, the Foundation's principal activity is that of making loans to Iowans attending medical school. Applicants must be in good academic standing and must be deserving of assistance. A liberal repayment plan is available. The recipients are not required to attend medical

school in Iowa; several, for example, are at Creighton University.

Where does the Foundation obtain its resources for the loan program and other activities?

Obviously, as loans are paid the money is recirculated. In addition, support comes, principally from physicians, in the form of gifts, memorials, bequests, etc. The voluntary contributions from Iowa physicians in the past six months has exceeded \$15,000. Support from various medical organizations has been vital to the Foundation program, e.g., \$1,600 has been contributed in 1973 and 1974 by the Iowa Academy of Surgery, a grant of \$5,000 has been received from the Inter-State Postgraduate Medical Association of North America. Nearly \$10,000 accrued to the Foundation in 1973 from the trust of Dr. Henry Albert who established this form of benevolence in his will.

Additionally, individual physicians, county medical societies and other medical organizations have loaned sums of money to the Foundation for use in the student assistance program. Nearly \$55,000 is on loan to the Foundation in this manner. Loans have been made by the Tama and Pottawattamie County Medical Societies this past year.

In addition to its medical student loan program, the Foundation has involved itself in such other projects as the Hawkeye Science Fair, the Iowa State Fair Hall of Health and the Des Moines Center of Science and Industry. Additionally, it has supported programs on physician continuing education, health care planning, employment of the handicapped, alcoholism education and sports medicine.

The Scanlon Foundation is guided by a 10-member Board of Directors. The 1974-75 Board is composed of James F. Bishop, M.D., Davenport, A. J. Havlik, M.D., Tama, John H. Kelley, M.D., Des Moines, Kenneth E. Lister, M.D., Ottumwa, Rubin H. Flocks, M.D., Iowa City, Lewis H. Jacques, M.D., Iowa City, George L. Baker, M.D., Iowa City, Ronald V. Saf, LL.B., Des Moines, Ivan Johnson, Des Moines, and Donald L. Taylor, Des Moines.

# IN THE PUBLIC INTEREST

# State Department of Health

### HEALTH ENGINEERING DIVISION

The Iowa State Department of Health has undergone a realignment of responsibilities in the environmental and engineering health areas. Two state agencies now handle the duties formerly overseen by the Environmental Engineering Service of the State Department of Health (SDH). These departments are: (1) the Health Engineering Division of the Iowa State Department of Health, and (2) the State Department of Environmental Quality (DEQ). There are additional agencies that handle various resource, conservation and environmental problems.

The SDH Health Engineering Division is concerned with *private* facilities and public health problems. The Department of Environmental

Quality handles *public* facilities and environmental problems.

The similarity in assignment has created confusion since both agencies are concerned with public welfare in the area of health. There is no clear dividing line between the two agencies. Physicians should be mindful the DEQ is involved with environmental problems and how they affect the total public. The SDH Health Engineering Division is concerned mainly with the health of the private citizen. An example of the distinction between public and private is: DEQ inspects and supervises construction and operation of public water supply facilities; the SDH Health Engineering Division inspects and supervises construction of private water facilities (wells, cisterns).

Remember: the Iowa State Department of Health is concerned with *private* health problems

## RESPONSIBILITIES OF IOWA STATE DEPARTMENT OF HEALTH

DIRECT

(Immediate responsibility lies with the Health Engineering Division of the Iowa State Department of Health)

YOUTH CAMPS
MUNICIPAL SCHOOL SWIMMING POOLS
MIGRANT LABOR CAMPS
MOBILE HOME PARKS
GRADE "A" MILK CERTIFICATION
STATE PLUMBING CODE
EMERGENCY RADIOLOGICAL ADVISORY

INDIRECT

(Immediate responsibility lies with the local city and county boards of Health with the assistance of the Iowa State Department of Health)

PRIVATE WASTE TREATMENT (privies, septic tanks)
PRIVATE WATER SUPPLY
RODENT (rats), INSECT CONTROL
HOUSING CODE
NUISANCE INVESTIGATION

# RESPONSIBILITIES OF THE IOWA STATE DEPARTMENT OF ENVIRONMENTAL QUALITY

CONTROL OF: AIR POLLUTION

WATER POLLUTION
PUBLIC WATER SUPPLY PROGRAMS

SOLID WASTE DISPOSAL

PESTICIDES AND OTHER CHEMICALS

NOISE POLLUTION

MONITORING, EVALUATING, CORRECTING PROGRAMS ISSUING CONSTRUCTION AND OPERATING PERMITS; TRAINING AND CERTIFICATION OF OPERATING PERSONNEL

INSPECTING: public water supply

waste water treatment facilities

open burning sites river and lakes feedlots mining sites

**ENFORCING POLLUTION CONTROL STANDARDS** 

that may affect the private citizen and his surroundings. "If it is mine and I have a question, I'll call Health Engineering."

The Department of Environmental Quality is

concerned with public health problems that may affect the general population and its surrounding environment. "If it is for everyone and I have a question, I'll call DEQ." (See Chart on page 229.)

### Morbidity Report for April, 1974

Disease	April 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties	Disease	April 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties
Adenovirus				_	Influenza-like				
infection	2	10		Marion, Woodbury	illness	1313	88828	10795	Carroll, Fayette,
Amebiasis	3	5	4	Boone, Dallas, Dubuque					Johnson, Linn
Ascariasis	3	4		Dubuque, Jasper, Pottawattamie	Influenza, lab confirmed	10	115	96	Scattered
Brucellosis	2	5	2	Black Hawk, Tama	Meningitis, type	3	13		Clinton House Indiana
Chickenpox	1047	4382	9020	Dubuque, Jackson, Linn, Polk, Story	unspecified Meningitis, aseptic, or vira		3	11	Clinton, Henry, Jackson Jasper, Linn, Polk
Conjunctivitis	104	312	656	Scattered	Meningitis, bact.	11 3	3		Jasper, Linn, Folk
Cylomegalovirus					due to H. inf.	1	3		Black Hawk
infection	3	19		Keokuk, Polk, Tama	Meningococcal		3		Didek Flank
Eaton's agent				·	Meningitis	1	4	7	Linn
infection	2	22	10	Delaware, Poweshiek	Meningo-				
Encephalitis, typ	e				encephalitis	1	1		Black Hawk
unspecified	I	11	9	Polk	Mumps	189	1338	2385	Carroll, Cass, Ida, Linn
Encephalitis, vira	al 3	10	5	Marshall, Polk, Scott	Pediculosis	28	183	80	Dubuque, Linn
Enteropathogeni	с				Pinworms	3	29	1	Benton, Dallas,
E. Coli	1	4		Fremont					Winneshiek
Erythema					Pneumonia	74	424	503	Scattered
infectiosum	108	216	1120	Hamilton, Poweshiek,	Rabies in animals		43	86	Scattered
Gastrointestinal				Taylor, Warren	Rheumatic fever	4	39	11	Appanoose, Carroll, Dubuque, Linn
viral inf.	852	4669	4801	Dubuque, Floyd,	Ringworm, body	16	86	61	Scattered
viidi iii.	002	1007	1001	Johnson, Linn, Marion	Ringworm, scalp	3	5		Scott
Giardiasis	3	8		Johnson, Polk, Winnebage	Rubella	5	12	151	Butler, Des Moines, Dubuque, Lee
Guillian-Barre		_			Rubeola	1	8	184	Des Moines
syndrome	1	3	2	Linn	Roseola	2	7	1	Dubuque, Mahaska
Hepatitis,					Salmonellosis	13	53	31	Scattered
infectious	18	118	103	Linn, Muscatine	Scabies	7	38	6	Johnson, Marshall, Polk,
Hepatitis, serum	10	34	19	Scattered	al a ll a				Scott, Story
Hepatitis, type	_				Shigellosis	13	41	97	Scattered
unspecified	3	14	6	lowa, Jefferson, Linn	Streptococcal infections	1017	5063	3516	Jackson, Johnson,
Herpes simplex	8	30	17	Buchanan, Johnson, Linn, Muscatine		1067		3510	Marshall, Polk
Herpes zoster	5	21	6	Black Hawk, Des Moines, Louisa, Polk	Toxoplasmosis Tuberculosis,	1	2		Henry
Histoplasmosis	3	6	3	Black Hawk, Decatur, Scott	active Tuberculosis,	18	36	39	Scattered
Impetigo	49	167	173	Scattered	inactive	1	2	9	Black Hawk
Infectious	7,	107	113	Juliolog	Venereal Diseases		1.45	101	Scattered
Mononucleosis	s 105	414	359	Johnson, Linn, Marion, Polk	Syphilis Gonorrhea	32 475	143 2023	121 1884	Black Hawk, Johnson, Linn, Polk



# The Physician and the Alcoholic

HAROLD F. MOESSNER, M.D., F. WILLIAM BENNETT, M.D., and CHESTER F. McCLURE, M.D.

Management of the alcoholic takes a good deal of time. Provided here are some guidelines intended to assist lowa physicians as they treat and refer to appropriate agencies those addicted to this drug.

THE PROBLEM OF ALCOHOLISM has received increasing attention in medical circles the past few years. Extensive treatment programs are being organized, general hospitals are admitting alcoholics as patients, labor-management contracts are providing special benefits for employees with alcoholism, third-party payments are being allowed by insurance carriers for alcoholics and courts are making special dispositions for the rehabilitation of persons with alcohol problems. The 1974 Iowa General Assembly is expected to consider a bill to decriminalize alcoholism and place the responsibility of detoxification in the medical field. A committee of the National Council on Alcoholism has established a set of criteria for the diagnosis of alcoholism.1

This discussion was prepared by the three physicians noted as members of the Iowa Medical Society Committee on Alcoholism. It has been presented to and accepted by the IMS Executive Council.

Approximately 70% of the adult population consumes ethanol at some time or other. Of these, 10% become truly addicted to this drug. This addiction is characterized by a pharmacological tolerance and a withdrawal syndrome. The physician is not immune to this particular illness. The American Medical Association estimates 400 physicians are lost each year to alcoholism and one half of the 100 physician suicides per year are alcohol related. In Arizona and Oregon there were 108 disciplinary actions against physicians due to alcoholism over a 10 year period.<sup>2</sup> This amounted to 2 to 3 per cent of the total number of physicians and is about equal to the graduating class of an average medical school.

In addition to persons addicted to alcohol, there are many more who abuse alcohol. This long term abuse produces numerous physical, psychological and social problems. The average life span of the heavy drinker is shortened by 10 to 12 years. The alcoholic has a suicide rate 55 times greater than normal and an accident rate 16 times above the average. Fifty per cent of all fatal traffic accidents are associated with an intoxicated driver. Forty per cent of all arrests are related to alcohol intoxication. Many divorces and separations are associated with alcohol abuse. Twenty to 30 per cent of all patients in general hospitals have an illness associated with excessive alcohol ingestion.

The Iowa Medical Society established a Committee on Alcoholism in 1970. The present mem-

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JUNE, 1974.

bers of this committee are: S. M. Haugland, M.D., Chairman, Lake Mills; F. W. Bennett, M.D., Cedar Rapids; R. E. Donlin, M.D., Harlan; G. W. Gray, M.D., Davenport; R. C. King, M.D., Clinton; C. F. McClure, M.D., Decorah; H. F. Moessner, M.D., Amana and L. B. Sedlacek, M.D., Cedar Rapids.

This committee has addressed itself to the preceding problems and many others related to ethyl alcohol. Since there is such a diversity of methods in the treatment of alcoholism, a subcommittee has developed guidelines for the treatment of alcoholic patients which have been approved by the committee and subsequently by the IMS Executive Council. Following are the recommendations:

## SUGGESTED MANAGEMENT GUIDELINES ACUTE ALCOHOL INTOXICATION

Acute intoxication with ethyl alcohol is an excessive ingestion of a central nervous system depressant similar to an overdose of barbituates and, therefore, should be treated medically. The fact that not many deaths occur in Iowa jails is a tribute to our law officers. To burden these professionals with providing medical care for intoxicated citizens in face of a climbing crime rate is an injustice in our modern society. The acutely intoxicated alcoholic should be observed and treated in a hospital. Fortunately, this type of problem does not require a great deal of medical care but does require close observation by a concerned nursing staff. Not all intoxicated persons require hospitalization for the detoxification process. Some can be sobered up at home or in an out-patient detoxification facility.

### ACUTE WITHDRAWAL

Acute withdrawal occurs after the abrupt cessation or abrupt decrease of alcohol intake in a person who has consumed large quantities of ethanol over long periods of time. Symptoms commence in eight to 12 hours with extreme anxiety and tremulousness. Within 48 hours the symptoms may progress to grand mal seizures and hallucinations. If proper treatment is not provided for the patient, the symptoms may progress to delirium tremens and death. A syndrome like DT's occurring after five days should be thoroughly investigated for some other cause. As a syndrome, delirium tremens consist of psychomotor hyperexcitability and confusion with or without convulsive seizures.

Nursing care is the most important aspect in the treatment of the withdrawing alcoholic patient. This should be provided by personnel who are trained and experienced in the care of the alcoholic. They must be able to observe the patient closely and project their concern for the patient's welfare. The best treatment for the patient's extreme anxiety is a large amount of positive reassurance. Physical restraints, isolation, loud noises, darkness and wild decor in the patient's room are to be avoided because they aggravate the patient's confusion and extreme anxiety. All medication should be given orally if possible.

### **SEDATION**

The use of drugs to quiet the agitated patient is mandatory in severe withdrawal. The amount of drug required is frequently above the therapeutic dose recommended by the manufacturer. The correct dose is the amount required to sedate the patient sufficiently so that he is able to sleep but can be aroused when necessary to check his vital signs, give oral feedings, or administer nursing procedures. Drugs which may be used are:

- (1) Diazepam (Valium®), 10 to 50 mg every 4 hours PRN
- (2) Chlordiazepoxide (Librium®), 100 to 300 mg every 4 hours PRN
- (3) Hydroxyzine HCl (Vistaril®), 100 to 400 mg every 4 hours PRN

All of the above medications can be given by mouth or intramuscularly. Diazepam can be administered IV but should be given directly into the vein at a rate of 5 mg per minute rather than administered through the IV tubing or in an IV drip.

For sleep Flurazepam HCl (Dalmane®) in 15 to 30 mg dosage is preferred. This may be repeated one time.

### **SEIZURES**

If the patient in withdrawal has a history of epilepsy or history of having seizures in a previous episode of withdrawal, the following drugs may be added:

(1) Diphenylhydantoin (Dilantin®), 100 mg QID. This drug is valuable in preventing seizures which may occur after 72 hours but will not prevent seizures prior to this time. Dilantin also has a beneficial effect on the central nervous system and the cellular membrane metabolism.

(2) MgSO<sub>4</sub>, 2 to 4 cc (500 mg per cc) IM. This drug may be helpful in preventing seizures and re-establishing the low serum and tissue magnesium levels found in the withdrawing alcoholic.

### FLUIDS AND DIET

Most patients in withdrawal will be over hydrated unless nausea, vomiting or diarrhea have been present.<sup>3</sup> Therefore, oral fluids are usually sufficient and the majority of patients will be able to eat solid food in 12 to 36 hours.

### VITAMINS

Since many alcoholics are poorly nourished, vitamin supplementation is indicated. Ethanol interferes with the absorption of folic acid, vitamin B-12 and thiamine from the small intestine; therefore, the vitamin preparation given to the patient should contain these three essential vitamins. Oral administration of the vitamin preparation is recommended.

### ANALGESICS AND ANTACIDS

Since salicylates can exacerbate the gastritis caused by ethyl alcohol, acetaminophen would be the drug of choice as an analgesic. Most antacids do provide relief from the acute gastritis and these may be used as needed.

### COMA

If the patient is in a coma and such measures as supporting the circulation and respiration, preventing aspiration, etc., do not produce improvement in the clinical situation, more intensive studies are urgently required. The alcoholic patient in withdrawal may present with cranio-cerebral trauma, diabetic acidosis, hypoglycemia, an acute infectious process, gastrointestinal hemorrhage, acute cardiac or respiratory failure, etc.

Through the years, an aura of fear and a tradition of over treatment has been established around the therapy of acute withdrawal of ethanol.<sup>4</sup> With very simple measures, as outlined here, adequate therapy can be provided for the patient in withdrawal with a mortality rate of less than one per cent.<sup>5</sup>

### FOLLOW UP THERAPY

After the patient has been taken through the withdrawal from ethanol, he and his physician need to evaluate the patient's situation. Does he have a job, a family, a home or friends? What is his general physical condition? Does he suffer

from a psychiatric illness? Is he seriously interested in a sober life, or does he want to resume drinking? The physician and the nursing staff should help the patient in this evaluation. In addition to a sincere interest and concern for the patient, the medical and nursing staff must provide some basic education about the disease of alcoholism and the chronic deteriorating effects of this drug. Also, referral to the proper community agencies may be the key to starting the patient on the road to sobriety. These referrals need to be expedited. Involvement of the agency during the hospitalization period is strongly recommended. Difficult admitting procedures and waiting lists at referral agencies may decrease the patient's chance of making it. Bridges need to be built to assure that the patient is receiving care and not fading away from treatment.6

### LONG TERM TREATMENT

In the past the majority of treatment for alcoholics was long term in-hospital therapy. Although this method was beneficial to many patients, it is a very costly method and a certain number of patients were able to avoid their many problems while hospitalized rather than attempting to solve these problems. Therefore, the tendency in recent years has been to shorten the in-hospital part of therapy and arrange for counseling in an out-patient setting after discharge.

### COUNSELING

Since counseling the alcoholic patient may involve long term and time consuming therapy, most busy physicians are not able to perform such service. There is no reason, however, that the physician cannot refer his patient to the proper community agency.

- (1) Community alcoholism offices. The State of Iowa has over 30 community alcoholism offices staffed with personnel trained and experienced in dealing with the alcoholic patient and his family. These offices may provide one-to-one counseling, group counseling, family or marital counseling, industrial counseling, etc. In addition, many larger community offices are associated with a half-way house for the patient in need of a temporary home.
- (2) Mental health centers. In most areas of the state, there is a community mental health center which may offer the same type of counseling as described here in addition to the usual psychiatric services.

### ALCOHOLICS ANONYMOUS

A.A. provides much more than counseling. For the patient who has to change his social activities from wet to dry, A.A. is the ready answer. For those patients who need spiritual involvement, A.A. seems to satisfy this need. And for the many empty hours which confront the alcoholic, involvement in 12 step work seems to fill this void and provides a great deal of self satisfaction. Dedicated and unselfish members of a local A.A. group can be of tremendous help to the busy physician in dealing with an alcoholic patient.

### **PSYCHIATRY**

In approximately 10% of all alcoholic patients, a definitive psychiatric diagnosis can be established. Although these diagnoses run the gamut of psychiatric illnesses, unipolar and bipolar depressions, personality disorders and neurosis seem to predominate. Three types of psychological defense mechanisms seem to be used by a majority of the alcoholics and the physician should be aware of these in dealing with his patient.

- (1) Denial ("I don't drink as much as they say.") Although the denial of the amount of drinking is most typical, the patient uses the same technique in avoiding the problems created by his drinking, such as the physical complaints, the poor work record, the marital and family conflicts, the arrest records, OMVI's, etc. The physician must unmask this denial and help the patient face the real life situation.
- (2) Depression. The usual anxiety that is induced by the excessive use of alcohol is frequently combined with a feeling of hopelessness, especially if the patient has made serious efforts to stay dry and has had a relapse. Also, the physician must not become discouraged by these relapses since they are similar to the relapses in other chronic diseases such as diabetes, chronic heart disease, chronic obstructive pulmonary disease, etc. In addition, the patient may be discouraged by his failing health and his failure in other areas.
- (3) Dependency Conflict. The alcoholic seems to experience difficulty with his interpersonal relationships and his self esteem. This often produces a patient who is extremely dependent on a spouse, mother, etc., or a patient who demonstrates a strong facade of independence but beneath this facade craves for a meaningful relationship with another human being.

### RELIGION

Although Alcoholics Anonymous emphasizes the spiritual aspects of recovery and the importance of the patient's faith in a supreme being, many patients may be more interested in an ongoing relationship with their family minister or priest. These professionals may also be extremely helpful in the solution of the other problems in the patient's family.

### DRUGS

Although drugs are extremely useful in the withdrawal phase of alcoholism, they must be used with extreme care in the continuing treatment of the patient. The sedatives, hypnotics, major and minor tranquilizers, etc., can lead to an addiction in the susceptible patient. The physician and his patient must realize that recovery lies not in another drink or another pill but rather in a solution to the patient's problem. The alcoholic patient is an expert in obtaining prescriptions from one or more physicians and the end result often is polypharmacy.

- (1) Antidepressants. Since depression is an important finding in the alcoholic patient, insomnia is also a common complaint. One of the sedative type tricyclic antidepressants may be useful. These can be given in single doses at bed time and do not produce the "high" which so frequently leads to addiction.
- (2) Disulfiran (Antabuse®). Disulfiran in the proper dosage can be an extremely useful drug. 500 mg should be given daily in the morning for one to two weeks, after which the dose can be decreased to 250 mg daily. When the patient takes this drug, he has committeed himself to 24 to 48 hours of sobriety. If the patient consumes alcohol in any form while taking Disulfiran, an antabuse-alcohol reaction occurs. This consists of flushing, throbbing headache, nausea, vomiting, dyspnea, palpitation, tachycardia, hypotension and syncope. The severity and duration of the reaction depends on the blood level of ethyl alcohol. The amount of alcohol in cough syrups or other liquid preparations may be sufficient to produce a reaction. Disulfiran is contraindicated in patients with severe cardio-vascular disease or severe psychoses only because of the stress resulting from an alcohol-antabuse reaction. The important drug interactions of Disulfiran occur with Diphenylhydantoin Isoniazid and oral anticoagulants.

Vol. LXIV, No. 6

Disulfiran should not be considered as a crutch but rather as a form of insurance. It will guarantee the patient a period of sobriety while he works on the solution of his problems and the change in his life style.

### SUCCESS OF THERAPY

What constitutes success in the treatment of an alcoholic patient? Total abstinence should be the goal of all therapy for alcoholism because with rare exception, another drink starts the patient on another cycle of physical, psychological and social deterioration. But physicians should not expect better results from the treatment of their alcoholic patients than they do expect from the treatment of their diabetic patients. Both illnesses are chronic diseases with multiple medical problems in most of the organ systems of the

The bill noted at the outset of this article to decriminalize alcoholism was passed by the 1974 lowa General Assembly. Beginning July 1, 1974, under certain circumstances, an individual apprehended for alleged intoxication may elect to be taken to a hospital rather than a jail. Local health care personnel should be aware of this new provision in the law.

human body. Diabetics do not always follow their diets, do not always take their medications as prescribed, etc. In addition, success in the alcoholic patient not only requires abstinence from ethanol but also definite change in attitude, behavior and feeling and a rehabilitation of physical problems. Therefore, success must be measured in longer periods of sobriety, an improved work record, a wholesome family situation and a better understanding of personal problems.

If physicians can accept and apply the preceding guidelines in the treatment of alcoholic patients, not only will medical care be improved for a large segment of our society, but such action will also earn the eternal gratitude of the concerned patients and their families.

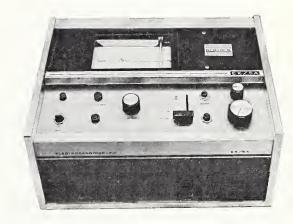
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1285 Thomas Beck Road Des Moines, Iowa 50315

# Jejuno-Ileostomy and Abdominal Lipectomy In the Treatment of Morbid Obesity

E. J. DREW, M.D.

Des Moines

A series of 550 cases covering four years are noted here with the author indicating a favorable experience. The criteria for surgery are noted as are the benefits and complications.

It has been estimated 60 million Americans are overweight, and more than 25 million are at least 15% above the Metropolitan weight table. Thus, it is obvious that obesity ranks high among the health problems facing modern civilization. Obesity has become associated with increased morbidity and mortality to present a health problem of epidemic proportions. Obesity is more a national health problem than undernutrition. We often see pictures of undernourished people who go to bed hungry at night; however, the number on the other end of the "scale" far "outweigh" the ones who are undernourished. Men and women in the United States are larger and heavier than their contemporaries around the world because of overnutrition and their sedentary habits. The hazards of overweight are well known: lower life expectancy, greater surgical risk, increased susceptibility to cardiovascular accidents and diabetes mellitus, etc.

In general, medical treatment has failed miserably in the treatment of obesity. Of every 100 people treated by conventional medical modalities, probably 12 will lose weight. As soon as the medical treatment is discontinued, 10 of the 12 will revert to their original status; this leaves two out of 100 who benefit from medical management.

The jejuno-ileostomy excludes approximately 92½% of the jejunum and ileum and has been employed for 16 years in the management of patients who are refractory to medical treatment.

Weight loss achieved in obesity clinics is usually transient. Weight lost during a period of hospitalization is often regained upon discharge. Once the patient leaves this sequestered and controlled environment, he reverts to his voracious eating habits and soon regains any lost weight at a great personal and financial sacrifice.

Jejuno-ileostomy is designed to circumvent the problem of high caloric intake. It actually creates a caloric leak to enable the patient to lose weight without altering his food consumption routine.

It is unnecessary to detail the physiology of digestion except to say that little or no digestion occurs in the stomach. This is primarily a storehouse for food. The absorption of amino acids, monosaccharides, glycerol and fatty acids occurs in the jejunum and ileum and in order to create a caloric leak, part of the intestine which is involved in the digestion and absorption must be circumvented.

### SURGICAL TECHNIQUE

Jejuno-ileostomy was developed by Dr. Howard Payne of the University of Southern California who performed the first jejuno-colostomy. He anastomosed 16 inches of jejunum to the mid transverse colon. This made the bypassed segment of bowel nonfunctioning and able to empty itself of its normal secretions and epithelial detritus. The original jejunal-colostomy produced undesirable sequelae such as intractable diarrhea, electrolyte imbalance, particularly those involving calcium and potassium ions, anemia, low prothrombin levels, hypoproteinemia and hepatic fatty infiltration. Restorative surgery became necessary in seven of the first 10 patients. As a consequence, the procedure was soon abandoned.

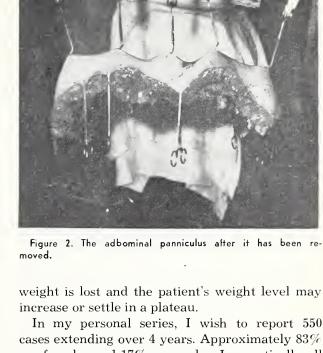
The weight loss following a bypass of the small

Dr. Drew is engaged in the private practice of surgery in Des Moines. Iowa.



Figure 1. Patient prepared on operating table before surgery.

intestine produces a gratifying fall in blood glucose, cholesterol and keratin levels. High blood pressure, shortness of breath and edema usually subside, and in many cases all menstrual irregularities are corrected. It is anticipated that a person having a jejuno-ileostomy will lose approximately eight pounds a month for the first year, or roughly 100 pounds total. A probable monthly loss of four pounds is to be expected in the second year. After the second year, little



weight is lost and the patient's weight level may

In my personal series, I wish to report 550 cases extending over 4 years. Approximately 83% are females and 17% are males. In practically all of the cases a concomitant lipectomy was performed. The amount of fat removed varied from two pounds to 43 pounds. The ages of the patients ranged from 12 to 62 years. The lightest patient weighed 180 pounds and the heaviest 550 pounds.

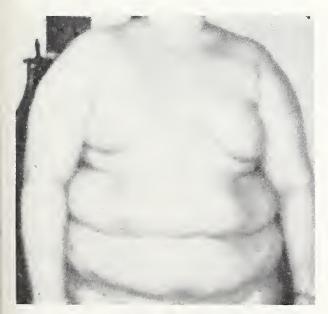


Figure 3. Female patient, age 24, with 1971 pre-surgical weight of 235 pounds.

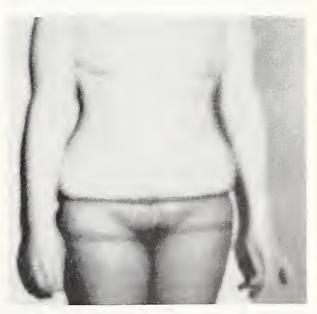


Figure 4. Same female patient with 1973 post-surgical weight of 145 pounds.



Figure 5. Male patient, age 21, with 1971 pre-surgical weight of 272 pounds.



Figure 6. Same male patient with 1973 post-surgical weight of 178 pounds.

Approximately one-third of the patients between 20 and 50 had cholelithiasis and a cholecystectomy was performed at the same time.

The problem of removing a large abdominal panniculus has been formidable. Use has been made of a sterilized Albee orthopedic bar taped to vertical operating room standards. This is then placed over the operating table where the panniculus is attached by Backhaus towel clips to the overhanging horizontal bar. After the panniculus has been excised, the detached portion is wheeled away from over the patient.

Procedures performed at the time in addition to cholecystectomy include ovarian cystectomies and occasionally an appendectomy. A routine appendectomy is not performed because of the fear of wound contamination.

Complications in the 550 cases consist of wound infection, intussusception, calcium and potassium deficiencies, and phlebothrombosis; pulmonary embolus occurred in two patients. Of the 550 cases, 10 deaths have occurred for the following reasons: (1) acute yellow atrophy of the liver or halothane hepatitis occurring three months following the original intestinal bypass, (2) hypokalemia, (3) coronary occlusion in two patients, (4) cerebral hemorrhage occurring two weeks following surgery, (5) overwhelming wound infection, (6) hepato-renal syndrome followed by hepatic failure and uremia, (7) cirrhosis of the liver, and (8) pulmonary embolism in two patients. Metabolic effects of the jejuno-ileostomy are (1) Diabetes (Many patients taking insulin or oral hypoglycemic agents prior to surgery experience a fall in the blood sugar to normal levels following a weight loss and the hypoglycemic medication was discontinued.); (2) Development of renal stones in a small percentage; (3) Drop in cholesterol and lipid levels; (4) Drop in uric acid levels; (5) Decrease in serum proteins; (6) Decrease in calcium and potassium ions, some patients require oral and intravenous supplementation; (7) Occasional arthritis. Most of these respond to conservative treatment and the employment of salicylic acid derivatives. In the 550 cases, there were no anesthetic or surgical deaths.

### PSYCHIATRIC BENEFITS

Many of these patients have emotional conflicts and a profound feeling of inferiority; some are introverts and recluses who refuse to associate with society.

The loss of weight is characterized by signifi-

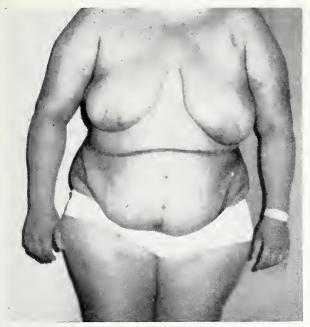


Figure 7. Female patient with 1971 pre-surgical weight of 300 pounds.

cant improvement in social status; often they are willing to be seen in public, and to travel in airplanes which they have not been able to do previously. The mental improvement is particularly significant in teenagers who are extremely self conscious when they weigh 300 pounds and have to attend school. If their weight can be reduced by one-third they are ridiculed less and there is a significant psychological improvement. Many have become economically self-sufficient and leave the public relief rolls.

### **PREGNANCY**

At least 30 patients had known pregnancies; practically all delivered without significant complications. One individual married 25 years had never become pregnant. She had a weight drop from 212 to 150 pounds, and delivered at age 42. There was some difficulty with electrolytes in this patient; however, they were ultimately corrected.

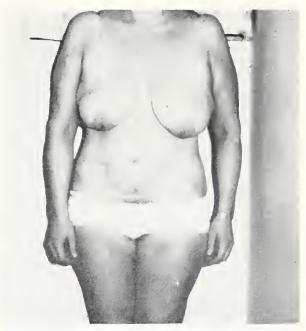


Figure 8. Same female patient with 1973 post-surgical weight of 185.

### CRITERIA FOR SURGERY

- (1) Age range from 20 to 60.
- (2) Inability to lose weight.
- (3) Weight at least 75 or 100 pounds over the Metropolitan table.
  - (4) A certain assurance of emotional stability.
- (5) Sufficient intelligence to handle side effects such as anal irritation and diarrhea.
- (6) Family stability and economic resources to handle expense in period of readjustment and unemployment.

The preoperative tests employed are (1) chest x-ray, (2) electrocardiogram, (3) serum iron, proteins and electrolytes determinations, (4) T3 and T4, (5) general profile, (6) triglycerides, and (7) electrophoresis.

In conclusion, 550 cases have been undertaken. The successes, failures, mortalities are highlighted with the improvement in metabolic disorders noted.

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# The Aging Face

CHARLES J. KRAUSE, M.D., and STEFAN DEMJEN, M.D. lowa City

Surgical procedures useful in restoring a more youthful appearance to the face are described briefly. Variances in the symptoms of facial aging between men and women exist and are noted.

Man's concern for his physical appearance can be traced to the very beginning of civilization. Early drawings illustrate a variety of marks upon the skin thought to represent that civilization's concept of beauty. Though the legendary search by Ponce de Leon for the "fountain of youth" stands out in history, man has persisted in a search for perpetual youth. Today the beauty aid industry is a multimillion dollar business.

The undeniable progression of senescence is generally first apparent in the skin. It is the skin of the face and neck in particular which serves as an embarrassing chronometer for all to see, even though the physical manifestations of aging bear no fixed relation to the chronologic age.

Many causative factors play a role in the aging of skin. Among them are: sudden weight loss, endocrine disorders, atrophy of underlying bony supporting structures, tugging of mimetic musculature, and the constant pull of gravity. By far the most important factors, however, are exposure to sun and weather. One need only compare the appearance of facial and neck skin with that of unexposed areas of the body to gain an appreciation of the role exposure plays. The tough,

craggy face of a merchant seaman is a classic illustration of the long-term effects of sun, wind and rain upon the skin of the face.

Histologic sections through areas of aging skin reveal disintegration of collagen bundles and atrophy of elastic fibers, loss of sebaceous glands, and thinning of the epithelial layer. With advancing age, these changes combined with the constant tugging of facial muscles and the force of gravity result in a progressive sagging of the skin and deepening of the lines of expression.

There are three groups of muscles about the face. Those which have to do with vision, those concerned with mastication, and those used for expression. It is of interest that nature has attached the muscles of expression to the skin for the purpose of expressing a variety of emotions, when it has been her consistent habit to use muscles in the appendages for function and protective purposes.

The skin is pulled into folds perpendicular to the long axis of the muscle when contraction occurs, and these folds in time become permanent wrinkles. Still later, as skin elasticity is lost, the wrinkles deepen into furrows. Because of its relation to emotions, the pattern of facial wrinkling may sometimes reveal a great deal about an individual's background and character.

To the permanent wrinkles of expression in adult life are added, in time, the so-called senile wrinkles. This fine wrinkling of the skin, which is most prevalent about the mouth, is due to wasting away of the subcutaneous tissue, shrinkage of the muscles, and absorption of the bony framework of the face.

Symptoms of the aging face are not entirely similar in men and women. Women complain generally of:

- 1. "Crow's feet" wrinkles in the lateral eye area and baggy eyelids.
  - 2. Glabellar frown lines.
- 3. Sagging cheeks, jowls and accentuated droop of neckline folds (turkey gobbler deformity).

4. Fine senile wrinkles around the mouth.

Dr. Krause is associate professor and vice chairman of Department of Otolaryngology and Maxillofacial Surgery at U. of I. College of Medicine. Dr. Demjen is a former member of Department and now serving as professor of plastic surgery at Comenius University, Bratislava, Czechoslovakia.



Figure 1. Preoperative Appearance.



Figure 3. Postoperative Rhytidectomy and Dermabrasion.



Figure 2. Preoperative Appearance.



Figure 4. Postoperative Rhytidectomy and Dermabrasion.

- 5. Fine wrinkling of the entire face.
- 6. Hyperpigmentoses and keratoses.

Men complain mostly of:

- 1. Male pattern baldness.
- 2. Marked forehead wrinkles.
- 3. Deep vertical frown lines over the central forehead.
- 4. Deep horizontal lines at the base of the nose.
  - 5. Drooping eyebrows.
  - 6. Baggy eyelids.
  - 7. "Crow's feet" wrinkles lateral to the eyes.
- 8. Deep nasolabial folds which may be prolonged down over the mandible.

Though little may be done to alter the aging process itself, the surgeon is able to restore a more youthful appearance to the face. It should be clearly appreciated by the patient that such surgical efforts represent merely an alteration in the aging pattern and do not materially affect the inevitable progression of the aging process itself.

A number of surgical procedures may be useful:

- 1. Blepharoplasty.
- 2. Submental lift.
- 3. Rhytidectomy.
- 4. Chemical peel.
- 5. Dermabrasion.
- 6. Excision of wrinkles.

The surgeon must carefully assess the nature and severity of those aging changes which exist before deciding upon a treatment plan. Therapy may include any or all of the procedures discussed in the following. The first three techniques are useful in correcting skin sag, and the remaining three are useful in correcting fine wrinkling of the skin.

### **BLEPHAROPLASTY**

Most patients who seek surgical correction of facial senescence require excision of baggy eyelid skin. Approximately 60% of them will have herniation of orbital fat through the septum orbitale as well. When drooping of the lateral eyebrow has occurred, an eyebrow lift may be combined with, or used instead of the upper blepharoplasty.

### SUBMENTAL LIFT

The submental wattle may be due simply to a sagging of skin, an excessive accumulation of subcutaneous fat, shortening of the platisma muscle, or all three. Sagging of the submental skin may be nicely ameliorated at the time of rhytidectomy without a separate submental incision. However, excision of submental fat and plication of the platisma muscle is best done through a separate submental incision.

### RHYTIDECTOMY

By undermining skin well out over the face and neck, excessive skin may be removed and the mimetic muscle insertions relocated. The incisions are all covered by hair except for that portion in the preauricular skin crease which is essentially invisible following maturation of the scar. In time the skin again stretches out, and a repeat rhytidectomy may be necessary in about 10 years.

### CHEMICAL PEEL

The application of a 0.5% solution of phenol to skin results in superficial necrosis of the epithelium. This technique may be useful in ameloriating fine, superficial wrinkles, chloasma, and lentigo. It has little or no beneficial effect upon skin sag.

### DERMABRASION

An abrasive may be used to de-epithelialize portions of the facial skin. The results of this technique are essentially the same as that of chemical peel.

### **EXCISION OF WRINKLES**

Occasionally very deep wrinkles may warrant excision. The efficacy of this technique is based upon the expectation that the resulting scar will be less disfiguring than the wrinkle which is removed. Careful planning of the excision and assessment for evidence of keloid tendencies is essential.

### SUMMARY

Though no method has been found to arrest the aging process itself, a number of techniques are available to relieve the manifestations of aging found on the face and neck. As the collagen bundles and elastic fibers slowly disintegrate and subcutaneous fat atrophies, the facial skin gradually sags. Repeated folding of the skin by muscles of expression accompanied by loss of skin elasticity slowly results in the formation of wrinkles and later deep creases. Rhytidectomy and/or blepharoplasty is effective in correcting skin sag. The fine wrinkling of skin is best treated by chemical peel or dermabrasion.



M. E. ALBERTS, M.D., Scientific Editor

# DECISIONS WITH SATISFYING RESULTS

This is the time of year when man is faced with decisions that may be great in magnitude. The future will depend on these decisions—not the far distant future but the ensuing 4-6 months. The winter season has kept the busy physician burdened with patients suffering varied respiratory diseases, gastrointestinal upsets, as well as the myriad of pathologic states which are not of seasonal incidence. Springtime does not bring a sudden cessation to these patient needs, but does provide another factor in the daily activities, along with another language that may not be understood by many; yet a language more universal than medical jargon.

Preparation for the decisions which might confront the involved physician may have been started during a cold, blustery winter evening in January while sitting before a cozy fireplace. Dreams of future results may have swirled up the chimney with the fragrant smoke of the fire, or may have been recorded for the decisions to be made later. Then, as warm zephyrs from the south melt the snow and ice, and the winter-bound inactivity, the future again sprouts in the thoughts to finally be consumated in the final decisions. The new language included such terms as Kentucky

Wonder, Fordhook, Mammoth Red Rock, Little Finger, Country Gentleman, Sweet Banana and Big Boy. Further, if there were more esthetic thoughts in the planning and decision making, Blue Danube, Star Joy, Senator Dirksen, Alpenglow or Lipstick may have been considered.

After decisions on such splendorous names have been reached, plans need be made regarding compatabilities, ultimate arrangements and continuing care. Timing will become a factor of importance. Sudden changes in climate can be disastrous. Improper placement can hide the beauty of some other effort. Ultimately all is in readiness, and the flowers and vegetables can be planted. The joys of being involved with growing plants can be as rewarding as observing the evolution of the growth and development of children. Challenges will be present as well, if that is desired in your life style. Plants have diseases, and may act unpredictably at times—even have behavior problems. (Not colic, though, I hope.)

Enjoy the great outdoors—plant a garden. The exercise is good, the cost is small compared to the cost of inactivity; furthermore, the television programs during the summer aren't very stimulating. In addition to all this, the results are delicious—the fragrance and beauty of the flowers, the taste of the vegetables, and the joy of giving your friends some of the fruits of your labor. M.E.A.

### INSTANT LEARNING

Many physicians consider the short chat over a cup of coffee in the doctors' lounge at the hospital as being unproductive and a waste of time. For some this may be true; for others it may serve as an unofficial form of postgraduate education. Patients often expect physicians to be secretive about the knowledge they possess. Certainly there are very few professions or industries that so freely share knowledge. We are constantly deluged with information in journals, some of which we voluntarily subscribe to, and

other which fall into the "throw-aways" category. We reserve no patent rights on new techniques or methods of treatment; in fact, we are eager to pass the information on to our colleagues for their patients' benefit. So it is over coffee in the doctors' lounge.

This morning four of us were chatting—two surgeons, an ophthalmologist and a pediatrician. One of the surgeons was discussing what he had learned at a recent postgraduate course. The rest of us profited by his experience and turned the discussion into a learning process. No secrets; no deals; no professional jealousy was exhibited—

### IOWA MEDICAL MISCELLANY

(Continued from page 225)

and IFMC; (7) opposed vigorously mandatory precertification of hospital admissions; (8) encouraged AMA efforts to require government hospitals to meet peer review standards; (9) reaffirmed commitment to peer review and urged IFMC to take appropriate steps to meet any contingency relating to PSRO or other quality assurance program; (10) urged IMS and AMA to continue constructive leadership to amend PSRO.

MORE HOUSE ACTION . . . The House also (11) issued a charter to the Student Iowa Medical Society; (12) set one-time \$5 dues for student members; (13) authorized Medical-Legal Committee to pursue professional liability matters; (14) sustained recommendation of Maternal and Child Health Committee to endorse disease eradication statement of State Department of Health; (15) called for 24-hour coverage of "Rural Medical Family Practice Units"; (16) urged dialogue at various levels in pursuit of effective use of physician's assistants and nurses; (17) approved 10-point statement of the Committee on Health Care in Correctional Institutions; (18) requested mailing of supplemental reports, excluding presi-

just a sharing of information. The public would profit by knowing that physicians do care about the welfare of the sick. Often the discussion may actually result in a curbstone consultation for the benefit of the patient at no added cost of a consultation fee.

Doctor, if the discussion in the lounge is something other than a replay of yesterday's bridge-hand or round of golf, it may be profitable for you (and your patient) to listen—or better yet join the discussion. There are no registration fees—no deductions either, but still something to be gained.—M.E.A.

dent's address, 10 days prior to House meeting; (19) reduced length of House sessions to two days with sentiment for Saturday/Sunday meeting; (20) asked for a resolution to AMA directing Council on Medical Education to evaluate further matter of continuing education, e.g., recertification, examination, documentation, etc.; (21) directed this concern over CME be transmitted to the Iowa General Assembly.

FINALLY... The House (22) authorized Drug Abuse Committee to investigate feasibility of a survey on physician prescribing practices with a further advance report to the House requested; (23) liberalized expense coverage for IMS president and board chairman when attending meetings for the IMS; (24) recommended modifying language covering election of district councilors; (25) approved halving dues for physicians in first two years of active practice, and authorized similar provision for physicians attaining age 70 if such action is recommended by the Board and upheld by the House.

FNP PROJECT . . . Society involvement in a "Family Nurse Practitioner for Use in Rural Iowa" has received Board approval. IRMP grant of \$80,000 to the Iowa Hospital Association will fund the project. Four IMS physicians will serve on an advisory committee.

# **Continuing Education Courses & Conferences**

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

June 3-5 Intensive Course in Pediatric Nutrition for Physicions

Summer Workshop on Alcoholism

June 10-12

American College of Physicians Refresher Course

June 26

Whot's New In Stroke

# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

# THE AGONAL STATE OF THE 'DIDACTIC LECTURE'

Some things die hard. For the past several years I've been led to understand that the lecture is almost taboo, at least for educational purposes. In fact, I've heard any number of eloquent speakers lecture sincerely and persuasively on that very point. Imagine what a surprise I felt then on reading this passage, which Harvey Cushing published in 1928!

"There are fashions in teaching, like fashions in other things, and one must conform or be regarded as out of date, even though, after all, we may reach our destination whether we ride sidesaddle or ride astride. Just now, for example, in our medical schools the "didactic lecture" is taboo—as much out of style as the crinoline or the bustle, admirably adapted as they were to conceal the defects of certain figures. The cut of our garments for the most part is determined for us by some unknown authorities in London or Paris for dire purposes of their own. We may cling to our old underwear, but outwardly we must adopt the particular design and frills others

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.

#### INDEX TO ADVERTISERS

Burroughs Wellcome 2	50A
Dain, Kalman & Quail, Inc	253
Gentec Hospital Supply Company	237
Iowa Trust Association	249

have thought becoming, or be smiled at. So it is with the fashions of teaching, and he who first put the taboo on lecturing was probably someone in authority incapable of holding the attention of a group of students by this method. I am glad of this, for I too am similarly defective, but feel, nevertheless, that if we wait long enough the didactic lecture, perhaps under another name, will return some day to popular favor as inevitably as the long skirt."

The lecture may not yet have regained favor among methodologic progressives when it is considered objectively as an educational technique, but it certainly has lost very little ground, to judge by the actual behavior of educators and those who plan educational activities. If the lecture is experiencing death throes, it is having as much trouble showing it as certain operatic heroines. And of course, there is no reason why the lecture ought to perish. If we would only choose it to do what it can do so well, and avoid it for the instruction that can better be provided in other packages, then all would be for the good. And we would restore the good name and reputation of an art noble since the time of antiquity. Perhaps Moses had a speech impediment, but loads of great teachers since have more than made up for it.

Lilly, Eli, & Company	232
McNeil Laboratories	231
Medical Protective Company	254
Milwaukee Sanitarium Foundation	227
Pharmaceutical Manufacturers Association 250D,	251
Prouty Company	256
Roche Laboratories 222-223, 250B, C, 259-	260

# Medical Assistants

by TENORA MEYER, CMA

#### OUR NEW PRESIDENT

Joann James became President of AAMA, State of Iowa, Inc., at the May 4 convention in Sioux City. Joann is a graduate of Mason City High School, Mason City Junior College (receiving an Associate of Arts degree as medical secretary), and Hamilton Business College. She is an 11-year employee of L. C. Orton, M.D., Mason City.

#### PRESIDENT'S MESSAGE

It is with sincere appreciation of your confidence in me that I assume this responsibility and



I thank you for the opportunity. The history of our Association is short but successful. AAMA, State of Iowa, has come a long way in 18 years because we have been diligent in our effort to give better service to our physician employers and

our patients.

A key to our success is contained in the word AWARENESS! Think about it—ARE YOU AWARE of what is happening in your local chapter, your state association and your national association? Are you aware of all that is offered from local, state and national levels? Are you aware that without YOU there is no local, state or national association? Are you prepared to do your part to make your association greater than

ever? We all have ability and talent in some form. Now is the time to make the most of it by offering of yourself to your Association.

I hope this year will be a successful one for our Association. I am pleased with my committee chairmen and members. It is important to remember we are working for you. If you have any problems, questions, criticism or whatever, feel free to contact me or another officer or committee member, as this is what you have elected us for—to work with you and for you!

We hope to instigate some new ideas in education and membership. We anticipate a series of traveling educational seminars across the state. This will enable more medical assistants to participate in continuing education without traveling several hundred miles.

Let's promote membership on an individual basis. Each member should be responsible for encouraging new members. This can be done most easily by showing others what an active member you are and how you have benefited from your membership. Changes made at the House of Delegates Meeting in Washington, D. C. have enabled us to expand our membership.

I have added two new committees. The first is a Health Careers Committee and the second is an Insurance Committee. I am asking each chapter to have a chapter chairman for these two committees.

Let's make this year our greatest yet, with substantial increases in membership, continuing education and invaluable service to our employers.

Let's make everyone AWARE that AAMA, State of Iowa, is an active, growing Association dedicated to the Service of our physician employers and their patients! This is the KEY to our future! With the key, WE CAN move Forward with Finesse. Thank you.—Joann James

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

# bite back

Taxes can and usually do eat up large portions of the successful professional person's income. And, being successful, you are also probably too busy to do much about it. There is, however, a simple and easy way for you to bite back at taxation. Turn your financial problems over to the Trust Department of your lowa bank. We understand the investment needs of professional people and can plan your investments to mitigate the effects of taxes. And, with an Investment Management Account or Living Trust we will handle all the detail work: bookkeeping, tax information and all the decisions involved in maintaining a sound investment program. To make it even better for you, our fee is tax deductible. So why try to be a do-it-yourself investment manager when your bank has a whole department of skilled and experienced people to do it for you? Iowa Trust Departments can save you time and money. Find out how . . . soon.



£ 1040

US Department of Individual

For the year January 1-December 31, 1971, or other taxable ye

Place label on form you file. orrect name, etc., if necessary. Enter social .urity number(s) y if incorrect or shown on label. Name (If joint return, give first names and in John Q. and Jane

Present home address (Number and street, inc 1776 Liberty Drive

City, town or post office, State and ZIP code Home town, Iowa 501

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1 Single

2 Married filing jointly (even if only one had inc

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Department of the Treasury Internal Revenue Service

► Attach to Form 1040

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John Q, and Jane D. Public

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 Partnerships, joint venture:

Name(s) as shown on Form 1040

John Q. and Jane D. Public

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# SCHEDULE D (Form 1040)

Department of the Treasury Internal Revenue Service

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Name(s) as shown on Form 1040

John Q. and Jane D. Public

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# Computation of Gasoline, Specia

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or other taxable year beginning \_ \_

John Q. and Jane D. Public

Part I

Gasc and Si



# Summary of IMS Group Coverages

In the past three years, the Iowa Medical Society Group Insurance Program has been expanded significantly and new coverages have become available to Society members. Those several coverages available through the Society's insurance administrator, The Prouty Company, are summarized here.

# ACCIDENT & SICKNESS DISABILITY— GUARANTEED RENEWABLE

This plan affords long term protection to those unable to practice due to accident or sickness. Weekly income benefits are available up to \$300 per week. Coverage allows lifetime accident benefits and sickness benefits payable for either two years, seven years, or unlimited to age 65 and two years thereafter to age 72. The definition of total disability is to be improved in 1974. Accident and sickness benefits payable under the L-7 plan will provide seven years' coverage for total inability to engage in your own occupation rather than profession. Under the L-65 plan benefits will cover the first 10 years of total disability from your own occupation rather than profession. Coverage is guaranteed renewable to age 70 under the special provisions. Longer benefit waiting periods from one to six months are available with a premium cost reduction from 20 to 45 per cent. Important additional features are available such as Specified Indemnities, Non-Disabling Injuries and Loss of Use of Hand or Hands.

#### LIFE INSURANCE

Low cost term insurance up to \$50,000 is available and includes *Waiver of Premium* and *Double Indemnity*. This individual non-cancellable coverage has rates guaranteed for the life of the policy. The policy may be converted to permanent insurance at any time without evidence of insurability. There will be an open enrollment during 1974 to permit any uninsured member under age 60 to apply for \$10,000 without underwriting, if certain basic requirements are met.

# OFFICE OVERHEAD EXPENSE DISABILITY— NEW GUARANTEED RENEWABLE

This plan will become guaranteed renewable in 1974. Greater stability will result. This is a form of disability insurance designed to pay fixed expenses of the insured when disabled by either accident or illness. Benefits are available from \$200 to \$1,500 monthly with coverage for 15 months. Waiting periods of either 14 or 30 days are offered. Benefits paid directly to the insured remain level to age 70. Premiums are deductible as a business expense.

#### EXCESS MAJOR MEDICAL—INDIVIDUAL

This plan provides true catastrophic protection up to \$100,000, or unlimited major medical benefits that start when the basic major medical insurance is exhausted. The plan pays 100% for eligible expenses for all causes for the family during each benefit period, after the deductible has been satisfied. The family deductible applies to expenses for all causes and for all covered members of the family, unlike ordinary plans based on a per person, per cause basis. The coverage is guaranteed renewable for life, premiums do not increase as you get older. Family deductibles are \$10,000 and \$15,000. The plan is available to supplement Medicare. It is anticipated that in the 1974 year there will be an open enrollment to announce several improvements in the plan.

#### ADDITIONAL PLANS

Other coverages for IMS members, families and employees are available through The Prouty Company. These include new higher limits of accidental death and dismemberment coverage providing 365-day protection at a low cost; life insurance for the Woman's Auxiliary to the Iowa Medical Society; "Gal Friday" income insurance protection for employees with tax-deductible premiums.

The Committee on Group Insurance serves as the Society's liaison with The Prouty Company. New coverages are considered and existing ones are reviewed on a periodic basis. Programs on insurance coverage may be arranged for county society or specialty group meetings through The Prouty Company. The Society insurance administrators expect to increase their counseling services in 1974 to include the areas of professional corporations, estate planning and business insurance.

Representatives of The Prouty Company will respond to any member inquiries. The address is 2124 Grand Avenue, Des Moines, Iowa 50312; Telephone—515/243-5255.

for a package insert in many instances. This would constitute a substantial saving for the manufacturer

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be crossindexed in a useful way.

# Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

# **Should Editorial Comments Accompany the Listings?**

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess

and indicate instances where a meaningful difference between drugs is pertinent.

# Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

should in no way imply control over the practitioner's prerogatives.

#### Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should not be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist. as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than pro-

duce another book, it makes muchmore sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

# Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level — a most dangerous trend for medicine.

# New Compendium — A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per

cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, not the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

#### Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005



# **About IOWA Physicians**

The following physicians were guest lecturers at Eldora training course for Emergency Medical Technicians—Ambulance: Dr. R. C. Rogers, Eldora, who is also medical advisor for the special course; Dr. Robert Thompson and Dr. J. J. Shurtz, Eldora; Dr. John Hughes, Marshalltown; and Dr. H. C. Gude, Iowa Falls. The course is to train ambulance drivers and attendants under state guidelines. It is sponsored in Eldora through the Iowa Valley Community College of Marshalltown. . . . Dr. R. E. Weland, Cedar Rapids, was guest speaker at "kick-off" meeting of Delaware County Cancer Crusade. . . . Dr. S. M. Haugland, Lake Mills, conducted a seminar session entitled, "Anatomy and Physiology Review" at North Iowa Area Community College in Mason City. Seminar was co-sponsored by Mason City Association of Medical Assistants and NIACC.

Dr. Duane Wilkin joined the Maquoketa Medical Center in January. Dr. Wilkin is native of Tabor, Iowa, and received the M.D. degree at U. of I. College of Medicine. He interned at Conemaugh Valley Memorial Hospital in Johnstown, Pa. For the past year and a half, Dr. Wilkin has been a general surgery resident at U. of I. College of Medicine. . . . Dr. J. G. Didmer, Wayland, has been re-elected president of Henry-Louisa County Community Mental Health Center. . . . Dr. Dohn Kruschwitz, Conrad, has been appointed to the Grundy County Board of Health.

Drs. John Bailey and Gerald Brown, Anamosa, recently moved into new medical clinic adjacent to the Anamosa Community Hospital. . . . Dr. W. M. Petty has been elected president of Buena Vista County Hospital medical staff; Dr. E. C. Laird, vice president; and Dr. T. E. Shea, secretary-treasurer. . . . Dr. Charles E. Hamm, Kingsley, was guest speaker at quarterly meeting of Tri-State Rescue and First Aid Association. . . . Dr. Robert S. Bell is new president of medical

staff at Memorial Hospital in Burlington; Dr. George Zimmerman, vice president; and Dr. Robert Allen, secretary. All are Burlington physicians. . . . Dr. Herbert Neff, Guthrie Center, has been named chief of medical staff at Guthrie County Hospital. Dr. D. E. Taylor, Stuart, is vice president; and Dr. J. L. Abramsohn, Guthrie Center, is secretary.

Dr. John Rhodes, Sr., Pocahontas, will serve as 1974 chief of medical staff at Pocahontas Community Hospital; Dr. James Gannon, Laurens, vice chief; and Dr. James Slattery, Pocahontas, secretary. . . . Dr. James G. Lott, D.O., Clarion, has been named president of Wright County Medical Society; Dr. A. F. Benetti, Belmond, vice president; and Dr. C. P. Hawkins, Clarion, secretary-treasurer. . . . Dr. Leonard Nelken, Clinton, gave an illustrated talk on his recent visit to Africa and the Aldabra Island Group at January meeting of the Clinton County Medical Assistants. . . . Dr. Adrian E. Flatt, professor of orthopedics at U. of I. College of Medicine, has been named president-elect of the American Society for Surgery of the Hand.

Dr. Robert E. Rakel, professor and head of U. of I. Department of Family Practice, was elected director of American Board of Family Practice at semi-annual meeting in January. . . . Dr. Fred Abbo, Cedar Rapids internist, was guest speaker at recent meeting of Linn County Dental Society. His topic, "The Aspects of Preventive Medicine." . . . Dr. (Major) Rodney R. Carlson, Ankeny, has assumed command of Iowa City-based 109th Medical Battalion of Iowa National Guard. Major Carlson has been a member of the Iowa Guard since 1963. He has served most recently as brigade surgeon of 34th Infantry Brigade headquartered in Boone. Presentation of the battalion colors to Major Carlson, signifying the official change of command, was made by Brig. Gen.

Joseph B. Flatt, commander of Iowa National Guard. . . . Dr. H. R. Light, Grinnell, has been elected chief of staff of Grinnell General Hospital. Also elected were Dr. Victor T. Wilson, vice-chief; and Dr. D. L. Ferguson, secretary. Both are Grinnell physicians.

Dr. James E. McGill, Carroll, was recently appointed to the board of the Carroll Chamber of Commerce. . . . Dr. Chester Janas, Independence, has been named medical director of Benton County Mental Health Clinic. Dr. Janas is completing his psychiatric residency at Mental Health Institute in Independence. . . . Dr. Laurence Lines has joined Dr. J. D. King in family practice in Nevada. A native of Cedar Rapids, Dr. Lines received the M.D. degree at U. of I. College of Medicine in 1971 and interned at Broadlawns Hospital in Des Moines. . . . Dr. Ervin Kjenaas, staff psychiatrist at Cherokee Mental Health Institute, is serving the Plains Area Mental Health Center in LeMars on a part-time basis. Dr. Kjenaas also gives some time each week to the Northwest Iowa Mental Health Center at Spencer. . . . Dr. James Coddington, Humboldt Chapter Chairman of Heart Fund, informed local residents at recent Heart Fund Kick-off meeting of the necessity for research, education and community service programs.

Dr. Dwain L. Eckberg, assistant professor in U. of I. Department of Internal Medicine, has been granted fellowship in the American College of Cardiology. Dr. Eckberg is one of 66 admitted recently to the College's highest membership classification. . . . Dr. Pacifico C. Ramon, pathologist from Jamaica, New York, has joined the staff at the Cass County Memorial Hospital in Atlantic. Dr. Ramon attended the University of Santo Tomas in Manila. He interned and took a pathology residency at Jamaica Hospital in New York. . . . Dr. George McGinnis, Fort Madison, is medical advisor for a Lee County emergency medical technician's course. Twenty-one ambulance attendants are enrolled. Lee County Medical Society is furnishing physicians to teach the 79-hour course which follows State Department of Health Guidelines. . . . Dr. Kennedy Fawcett, Ames, recently addressed physicians and coronary care nurses at the Hamilton County Hospital in Webster City. His topic: "Heart Diseases and Pacemakers."

Dr. K. A. Garber, Corydon, was guest speaker at

"Kick-off Meeting" of Lucas County Cancer Crusade in Chariton. . . . Dr. Daniel Bray, Algona, discussed "Facts and Fallacies of Aging," at adult education course for senior citizens in Algona. . . . Dr. Najed Chaarani, Shenandoah, recently attended a Conference of American College of Chest Physicians in Hawaii. . . . Dr. Richard McKay, Waterloo, was guest speaker at recent meeting of Northeast Iowa Diabetic Association. Dr. McKay discussed loss of vision due to diabetic retinopathy and use of the laser beam for treatment of such cases. . . . Dr. R. D. Berge, Aurelia, and Dr. Paul D. Boone, Paullina, have been appointed to hospital medical consulting staff at Cherokee Mental Health Institute.

Drs. Don Penly and John Keiser, Cedar Falls, were guest speakers at five-week seminar on "Death and Dying" sponsored by the community's Valley View Baptist Church. . . . Dr. Elmer L. DeGowin, professor emeritus, U. of I. Department of Internal Medicine, has been awarded a mastership by the American College of Phy-

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sicians. The mastership is the College's highest honor. . . . New officers of the Keokuk County Medical Society are—Dr. Lee McClenahan, president; Dr. C. A. Perkins, vice president; and Dr. P. Jutabha, secretary and treasurer.

Drs. J. J. Hruska and B. J. VanderKooi will join Storm Lake's Buena Vista Clinic in July. Dr. Hruska and Dr. VanderKooi are completing a second year of family practice residency at Broadlawns Hospital in Des Moines. . . . Dr. Truce Ordona, Davenport, was guest speaker at recent seminar on "Child Abuse" in Estherville. He discussed the child abuse bill now before the Iowa General Assembly. . . . Dr. Richard Long, Waterloo, is chairman of 1974 Gift of Life campaign of the Northeast Iowa Chapter of the Kidney Foundation of Iowa. . . . Dr. Albert Dolan, Evansdale, is new member of the Black Hawk-Buchanan Joint County Board of Education. Dr. Dolan is also president-elect of Black Hawk County Medical Society and serves as IMS District VI Councilor.

**Dr. Harold Brenton** is new chief of staff at Mason City's Memorial Hospital; **Dr. Ki Song**, vice president; and **Dr. Bruce Dunker**, secretary. All are Mason City physicians. . . . **Dr. Patrick Kain**, New Hampton, is new board member of Minowa

Area Health Planning Council. . . . Dr. Joseph D. Brown, associate professor, U. of I. Department of Internal Medicine, was guest speaker at recent meeting of Linn County Medical Society. He discussed diabetes and its various complications. . . . Dr. Ronald Bendorf, Council Bluffs, has been named medical director of the Pottawattamie Mental Health Center Corporation. He has been acting director since January when Dr. Bulent Tunakan resigned to devote full time to private practice. Dr. Bendorf is also an assistant professor of psychiatry at the University of Nebraska. . . . Dr. Herbert E. Buchsbaum, associate professor, U. of I. Department of Obstetrics and Gynecology, was guest speaker at "kick-off" meeting of the Tama County Chapter of the American Cancer Society. His topic: "Cancer Detection-Past, Present, and Future."

Dr. John Doran, Ames, was guest speaker at recent Extension Program in Clarion entitled, "Better Health for Women." Dr. Doran discussed cancer, menopause and birth control. . . . Dr. Santiago Garcia began solo practice of family medicine in Urbandale, a Des Moines suburb, April 1. A graduate of the Medical School at the University of Madrid in Spain, Dr. Garcia has been a staff physician at Woodward State Hospital for nine years.

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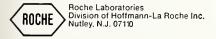
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Before deciding to make Valium iazepam) part of your treatment an, check on whether or not the itient is presently taking drugs d, if so, what his response has en. Along with the medical and cial history, this information can elp you determine initial dosage, e possibility of side effects and the timate prospects of success or

While Valium can be a most elpful adjunct to your counseling, should be prescribed only as long excessive psychic tension persists d should be discontinued when ou decide it has accomplished its erapeutic task. In general, when sage guidelines are followed, ılium is well tolerated (see osage). For convenience it is availle in 2-mg, 5-mg and 10-mg tablets.

You should be aware of the ssibility of side effects in some tients and should consult the mplete product information before escribing.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are eoneomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity eaused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaueoma; may be used in patients with open angle glaueoma who

are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanee (convulsions, tremor, abdominal and musele eramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropies or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual preeautions indicated in patients severely depressed, or with latent depression, or with suieidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundiee, skin rash, ataxia, constipation, headaehe, incontinence, changes in salivation, slurted speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased musele spasticity, insomnia, rage, sleep disturbanees, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term

Dosage: Individualize for maximum beneficial effect. Adults: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; aleoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal musele spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. Geriatric or debilitated patients: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) Children: 1 to 21/2 mg t.i.d. or q.i.d. initially, increasing as needed and

tolerated (not for use under 6 months).

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Times change, obviously. Circumstances change. Pressures mount, from different sources. Governmental encroachment casts its lengthening shadow. Divisiveness appears, with its splintering nature. Professionalism is subject to the test.

When we air differences in the press, misunderstanding results. Confidence, which has taken years to develop, is eroded. We must maintain patient (public) confidence to the fullest extent possible.

I don't agree with every AMA action. I don't agree with every IMS action. But I offer my personal assurance, as an Iowa physician and as your current president, that I will work within our long-standing professional framework to make my feelings known and then accept the majority opinion.

This is the way I see the profession operating in a democratic setting. I hope you do, too.

Sincerely,

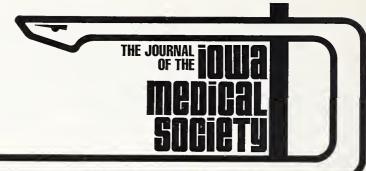
Ralph L. Wicks

Ralph L. Wicks, President

# Fifty Year Club Members

June 1, 1974

Anderson, Harold N Des Moines	Larimer, Robert N Sioux City
,	Leffert, Frank B Centerville
Banton, Oscar H Charles City	Loving, Luther W Estherville
Barnett, Sylvester W Cedar Falls	
Bartlett, George E New Sharon	McBride, Robert H Sioux City
Bessmer, William G Sun City, Arizona	McCreight, George C Carmel Valley, California
Billingsley, John W Newton	McKitterick, John C Burlington
Block, Charles E Davenport	Marquis, George S Des Moines
Bone, Harold C Des Moines	Maxwell, Charles T Sioux City
Braunlich, George Davenport	Maxwell, John, Sr
Brereton, Harold L Emmetsburg Brinkman, William F Pocahontas	Mooney, James C Des Momes
Broderick, Clarence E	
broadlen, charence 2 Short one	Neuzil, William J Cedar Rapids
Caulila Assas W	
Carlile, Amos W Manning Carstensen, Albert B Linn Grove	O'Brien, Stephen A Mason City
Christensen, John R Menlo Park, California	
Cooper, Gladys A Plattsburgh, New York	Palmer, Carson W Guttenberg
Crawford, Robert H Burlington	Pearson, George J Burlington
3	Peasley, Harold R Des Moines
Dahl, Harry W Des Moines	Peterson, Frank R Cedar Rapids
Dahlbo, John E Sutherland	Phillips, Clarence P Clear Lake
Doane, Grace O Des Moines	Piekenbrock, Frank J Dubuque
Dyson, James E Phoenix, Arizona	Preece, Wade O Waterloo
Egermayer, George W Elliott	Reuber, Roy N Mason City
Egermayer, deorge W Emote	Reuling, Frank H Waterloo
The All C	Richmond, Frank R Fort Madison
Felter, Allan G	Rock, J. Emmet Bettendorf
Fillenwarth, Floyd H	
Foster, Wayne J Cedar Rapids	Saar, Jesse L Laguna Hills, California
Franchere, Chetwynd M Mason City	Schnug, George E Dows
Frank, Owen L Maquoketa	Senty, Elmer G Davenport
,	Simmons, Ralph R Bloomfield, Connecticut Smith, Lawrence D Des Moines
Gernsey, Merritt Visalia, California	Sones, Clement A Des Moines
Gibson, Paul E Des Moines	Strawn, John T Vinton
Gillett, Francis A Oskaloosa	Stroy, Herbert E Osceola
Gittler, Ludwig Fairfield	Synhorst, John B Des Moines
Goggin, John G Ossian	
Gottsch, Erwin J Shenandoah	Taylor, Robert S Davenport
Gutch, Roy C Knoxville, Tennessee	Thomas, Clyde E Croton-on-Hudson, New York
	Thompson, Kenneth L Oakland
Harken, Conreid R Osceola	Thornton, John W Lansing
Harrington, Raymond J Sioux City	Trey, Bernard L Marshalltown
Hill, Lee Forrest Des Moines	
Hopkins, David H Des Moines	Van Camp, Thomas H Breda
Hornaday, William R., Sr Des Moines	Van Metre, Paul W Rockwell City
	Victorine, Edward M Cedar Rapids
Jensen, LeRoy E Audubon	Vineyard, Thomas L Ottumwa
Jerdee, Ingebrecht C Clermont	Vorisek, Elmer A Eureka Springs, Arkansas
Kast, Donald H Des Moines	Wahrer, Frederick L Marshalltown
Kelly, Dennis H., Sr Des Moines	Weems, Nev E Paullina
Kilgore, Benjamin F Des Moines	White, Harold E Knoxville
Kimball, John E West Liberty	Wilcox, Edgar B Oskaloosa
Kleinberg, Henry E Des Moines	Wilson, Fredric L Eugene, Oregon
Knight, Benjamin L Cedar Rapids	Wise, James H Cherokee



VOL. 64 No. 7 JULY, 1974

TABLE OF CONTENTS		Reports of Standing Committees	281
		Reports of Special Committees	289
President's Page	264	Supplemental Report, Board of Trustees	300
Fifty Year Club Members	265	Iowa Foundation for Medical Care, Report to IMS House of Delegates	302
President's Remarks— On Quality Medical Care in Iowa		Supplemental Report, Blue Shield	303
Rubin H. Flocks, M.D.	267	Informational Report—Scanlon Medical Foundation/Iowa Medical Society	307
Installation Remarks— Sees Understanding as Most Important		Supplemental Report, Judicial Council	308
Ralph L. Wicks, M.D.  State Department of Health	269 270	Supplemental Reports of Standing Committees	310
In the Public Interest	274	Supplemental Reports of Special Commit-	
County Society Officers	276	tees	313
Official Proceedings of the 1974 Sessions of		Resolutions	318
the House of Delegates, Iowa Medical		Life and Associate Memberships	321
Society	277	Reference Committee Reports	323
Reports of Officers	278	Officers and Committees of the Iowa Med-	
Report of Treasurer	280	ical Society 1974-1975	329
Report of IMS Judicial Council	281	Index to Minutes	335

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#### President's Remarks

# On Quality Medical Care in Iowa

RUBIN H. FLOCKS, M.D. Iowa City

Humility, confidence, dedication, charity, human understanding—these qualities must be demonstrated by Iowa physicians. So said IMS President Rubin Flocks in remarks to the Society's House of Delegates.

FIRST, I WANT to tell you what a privilege it has been to serve this year as President of the Iowa Medical Society. The officers, members and staff of the Society really made it possible for me to do the job. There has been a tremendous team effort by many persons to carry on the many Society activities.

What is the purpose of the Iowa Medical Society? This can be stated simply. The Iowa Medical Society is an association of physicians, so organized to make it possible for the people of Iowa to get the best of medical care. Everything we are doing is done to make it possible for our communities in this State to get the best of medical care.

The reports in the 1974 Handbook for the House of Delegates demonstrate how complex this work is and how much the profession is doing. Don Taylor and his administrative staff have done much to help in carrying out our work.

It would be redundant and unnecessary for me to amplify on the subjects covered in the various

reports. There are, however, a few things I want to emphasize.

#### NATURE OF MEDICAL CARE

I believe in order to provide top quality care, it is important to emphasize the nature of medical care. Quality medical care is infinitely intimate in nature, the relationship between patient and physician that is. It is infinite in its variety and, at the same time, in its need to utilize all the modern instrumentation and technology we have available, this for the benefit of the individual patient. This is an extremely important facet because it is something a little different from merely putting numbers down and feeding them into a computer.

The mortality rate for prostatic surgery is under one per cent but if you happen to be in that under one per cent, it is 100 per cent. Dr. Alcock (Nathaniel Alcock, Dr. Flock's predecessor as head of the U. of I. Department of Urology) emphasized that statistic. Our patients need to know that what is happening today in the legislative arena and elsewhere will hamper this intimate kind of relationship we have with our patients.

The increasing public expectations and our need to demonstrate public accountability and the need for team activity must not divert us from maintaining the kind of patient relationship I have described. Increased demand for accountability can create various additional forms of ancillary health personnel. This will alter techniques and reimbursement procedures. These must be weighed against their effect upon the patient/physician relationship. If this is not maintained, the delivery of medical care will be rigidified and reduced to mediocrity. It will become defensive. Innovation will be stifled and the tremendous advances in the delivery of medical

These remarks were presented by Dr. Flocks on May 11 at the opening session of the 1974 Annual Meeting of the Iowa Medical Society House of Delegates.

care in this country will diminish in comparison with the past.

#### RELATION TO EDUCATION

There is another area I want to emphasize. The Iowa Medical Society has maintained a continuing relationship with the University of Iowa, with the medical education structure in the State. This has been very constructive. It became increasingly constructive with the passage of the Haskell-Klaus-Perkins Law which was aided by the Iowa Medical Society. This relationship must be maintained and enhanced. The administration of both the University and the College of Medicine recognize the importance of a positive relationship with the Society. Such joint effort will assure that the education of physicians is maintained in a continuous manner, so that the education of the younger physicians in the College of Medicine may be leavened through association with those who are actually practicing medicine in the State. Your support and continuous involvement in the activities of the College are necessary. The more unity and cooperation we can promote between the medical school and the Medical Society, the better image we can develop with our patients, and through them with the Iowa General Assembly and the Congress of the United States. This is extremely important.

We must offer an open forum in the Iowa Medical Society, so everyone has his say. Every member should be privileged to contribute his ideas as to how best to deliver the best medical care to the community. But once the policy has been determined, the positions established, we must then try to present them in a unified manner. We must present them to our patients and allow their influence to have its impact on the various legislative bodies.

#### UNITY AND CONCORD

We must have unity and concord in the medical profession in this country. We have to demonstrate various qualities: humility, enough ego drive to gain patient confidence and acceptance of what we are doing, dedication, charity and human understanding. With these, we will find it possible to give dedicated, individual and quality medical care to the people of Iowa.

Thank you again for the privilege of serving as President of the Iowa Medical Society.



PROGRAM COMMITTEE—Five of the eight members of the 1973-74 IMS Program Committee are pictured here. This Committee planned and presented the Scientific Program April 18-20 in Iowa City. From left, C. P. Hawkins, M.D., Clarion, J. E. Tyrrell, M.D., Manchester, R. D. Whinery, M.D., Iowa City, chairman, H. J. Smith, M.D., Des Moines, and R. M. Caplan, M.D., Iowa City. Not pictured, L. J. Gugle, M.D., Ottumwa, J. F. Murphy, M.D., Boone, and S. E. Ziffren, M.D., Iowa City.

#### Installation Remarks

# Sees Understanding as Most Important

RALPH L. WICKS, M.D.

Boone

New IMS President lauds the Delegates on the actions taken at the May House meeting. He cites in particular the lowa Foundation for Medical Care, peer review and PSRO. He urges effort to secure public understanding.

DR. FLOCKS HAS GIVEN us many things to think about in his year as President of the Iowa Medical Society. He is a busy man with lots of commitments but he has always been ready and willing to help in any way he could. We are grateful for his efforts.

First, the Speaker said my acceptance speech should be brief, and on a second occasion, he said it should be very brief. I will try to make it so.

I would like to introduce those of my family who are present. My son, Douglas. My wife, Bunny. You know, they say a good wife is one who puts up with you when you are well and sits up with you when you are sick; Bunny does that, and much more.

My partners and colleagues in Boone deserve acknowledgment. They have been great about allowing me time off to do the things necessary this past year, and I am sure this will continue. They have been very cooperative, and I appreciate it very much.

#### HOUSE ACTIONS

The actions of the 1974 House of Delegates

have been taken after an excellent period of deliberation. The issues have been discussed, and the Reference Committees have separated the seed from the chaff, so to speak. I think they have done a wonderful job.

Based on the content of the last report, I am not so sure but that we may have to have another meeting of the House in the fall. We will have to see about this.

The House has given us, the Board and the officers, direction on how to conduct Society affairs. I was particularly pleased with the response of the delegates to the Foundation and its relationship to peer review and PSRO. The Iowa Medical Society and the Iowa Foundation for Medical Care, along with local societies and medical staffs, have been doing and will be able to continue doing peer review. I hope they will be able to do it correctly and properly, without too much government intervention, but they will have to stay within the confines of the law. As long as the law (P.L. 92-603) is in existence, we have to abide by it.

Our relationships with Blue Shield have been the best ever, I believe, and I think a lot of thanks must go to Sam Leinbach for the wonderful work he has done over the years for the Society and Blue Shield. We are going to miss him.

As far as Society committee assignments are concerned, I plan some changes. I am trying to get some younger people on committees. We are going to leave spaces for students on the regular and special committees.

Dr. Howard gave us many things to think about in his banquet address last night. The news was not what we wanted to hear but we must listen and be informed about activities in Washington, D. C., and at AMA headquarters in Chicago.

Dr. Wicks presented these brief remarks on May 13, 1974, following his installation as 1974-75 President of the Iowa Medical Society.

#### UNDERSTANDING

Our efforts toward public understanding must be extensive. You know that public education is essential when you hear a legislator declare that chiropractors have received the same amount and the same quality of education as physicians and osteopaths. And then to have this statement go unchallenged on the floor of the General Assembly. We must inform our legislators at the grass roots, on the local level.

I have a great amount of pride in the Iowa

Medical Society, its officers, its delegates, its members and its staff. To have been placed in this position by you, the delegates, is an honor, a great personal satisfaction and, naturally, the high point in my professional life. I accept the challenge of the office, confident that, with your guidance and support, the problems of the year ahead will be met with clear understanding and with progress toward our goal, which is continued high quality medical care to all the citizens of the State of Iowa. Thank you.

#### Morbidity Report for May, 1974

Disease	April 1974	to Date	1973 to Date	Most Cases Reported From These Counties	Disease	АргіІ 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties
Adenovirus					Infectious				
infection	- 1	11	I	Polk	Mononucleosis	113	527	426	Scattered
Amebiasis	3	8	7	Boone, Jefferson, Muscatine	Influenza-like illness	365	89193	11246	Johnson, Linn, Warren
Adcariasis	1	5		Jasper	Influenza,				
Brucellosis	2	7		Buena Vista, Dubuque	lab confirmed	- 1	116		Dubuque
Chickenpox	1278	5660	10255	Dubuque, Linn, Marion, Pottawattamie	Meningitis, type unspecified	2	15		lda, Washington
Conjunctivitis	157	469	756	Scattered	Meningitis,				
Cylomegalovirus					aseptic	- 1	4	2	Butler
infection	6	25		Johnson	Mumps	219	1557	2784	Cass, Linn,
Eaton's agent									Pottawattamie, Tama
infection	1	23		Polk	Pediculosis	45	228	89	Cerro Gordo, Linn
Encephalitis, type	e				Pertussis	3	7		Scott, Sioux
unspecified	1	12		Polk	Pneumonia	79	503	592	Scattered
Enteropathogenia	5				Rabies in animal	s 13	56	110	Scattered
E. Coli	1	5	2	Webster	Rheumatic fever	2	41	14	Appanoose, Hamilton
Erythema					Ringworm, body	9	95	67	Scattered
infectiosum	240	456	1297	Jasper, Warren	Rubella	2	14	166	Dubuque
Gastrointestinal					Rubeola	20	28	237	Clinton, Dubuque, Scot
viral inf.	675	5344	5134	Dubuque, Floyd, Ida, Johnson	Salmonellosis	6	59	42	Buena Vista, Clay, Dubuque, Marshall
Giardiasis	6	14	2	Boone, Jasper, Johnson,	Scabies	7	45		Johnson, Scott
				Polk	Shigellosis	23	64	112	Black Hawk, Dubuque,
Guillian-Barre					•				Johnson, Polk
syndrome	1	4	3	lowa	Streptococcal				
Hepatitis,					infections	1014	6077	4044	Dubuque, Jackson,
infectious	35	153	116	Linn					Johnson, Polk
Hepatitis, serum	7	41	21	Cerro Gordo, Johnson,	Tuberculosis,				
•				Linn, Polk	active	10	46	44	Scattered
Hepatitis, type					Tuberculosis,				
unspecified	1	15		Scott	inactive	5	7	12	Floyd, Jones, Linn,
Herpes simplex	9	39	28	Johnson, Polk,	Venereal Disease				Pottawattamie
H	2	2.4		Washington	Syphilis	s: 36	179	150	Scattered
Herpes zoster	3	24		Des Moines, Johnson Polk	Sypniis Gonorrhea	36 534	2557	2346	Black Hawk, Linn, Polk,
Histoplasmosis Impetigo	1 21	7 188	198	Polk Scattered	Gonorrnea	J34	200/	2340	Scott

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ANNUAL MEETING—TOP: LEFT—Distinguished Service Award Winner S. P. Leinbach, left, and Merit Award Winner J. H. Sunderbruch. RIGHT—IMS officers, left, T. E. Kiernan, vice-president; J. F. Bishop, Board chairman; V. L. Schlaser, president-elect; A. J. Havlik, trustee; seated, R. L. Wicks, president. MIDDLE: LEFT—H. J. Smith, left, retiring AMA delegate with successor, Erling Larson, Jr. RIGHT—Julian Bruner, with Mrs. Bruner, admires his Interstate Postgraduate Teaching Award. LOWER: LEFT—New IMS Life Members D. H. Kast, B. F. Kilgore and H. C. Bone. RIGHT—J. W. Eckstein, Dean, U. of I College of Medicine, left, receives AMA-ERF check from Board Chairman J. F. Bishop.



74 HOUSE OF DELEGATES—TOP: LEFT—R. D. Whinery, right, and L. D. Caraway, center, present trophy to Erling Larson, Jr., retiring IMPAC chairman. RIGHT—Gladys Manning, assistant vice president, Iowa State Bank, Iowa City, receives Sanford Award for service to student Ioan program. UPPER MIDDLE: LEFT—Judicial Council members, left, Hormoz Rassekh, new secretary, J. D. Kimball, new District X councilor, S. A. Smith, new District IX councilor, seated, J. E. Tyrrell, new chairman. RIGHT—S. P. Leinbach, with Mrs. Leinbach, receives second-ever Distinguished Service Award. LOWER MIDDLE, LEFT—Student Ioan recipients Ed Nassif, left, and John Rogers flank Scanlon Foundation President J. F. Bishop. RIGHT—President Flocks, left, receives silver bowl from President-elect R. L. Wicks. LOWER: FROM LEFT—C. E. Radcliffe, Blue Shield president; Reference Committee chairmen E. C. Laird, P. M. Seebohm and D. J. Soll.

# ACCEPTANCE OF AMA/CPT GAINING MOMENTUM

RESOLVED, That the Iowa Medical Society adopt and recommend that all members use the five-digit system as described in the current procedural terminology."

This resolution was adopted in April 1973 by the policy-making IMS House of Delegates. What does the action mean?

It means simply the medical profession is advocating and implementing a comprehensive and concise system of reporting (by uniform terminology and code) medical services. The Iowa Medical Society is urging broad use of this approach not only by its physician members, but by Blue Shield, Medicare, Medicaid and the private insurance companies.

The system is based on a significant reference volume. This is the American Medical Association (AMA) book entitled Physician's current procedural terminology (CPT). This third edition of the AMA/CPT is the product of the efforts of a 12-physician editorial board assisted by 41 consultants from 30 specialty groups. Extensive effort has made this volume more accurate in its definitions, simpler to use, and more comprehensive than its predecessors or any other similar volume. Of the 5,000 procedures and services contained in the current edition, some 2,000 are either new or have been revised since the 1970 issue.

What precisely is the AMA/CPT?

The AMA/CPT is a comprehensive reference listing of medical terminology with a numerical coding. It is intended to aid (1) physicians in recording and reporting diagnostic and therapeutic procedures, and (2) other organizations handling the administration of health care programs. Each of the more than 5,000 medical procedures has its individual five-digit code number to permit easy recording.

How does the AMA/CPT have value in a physician's practice?

It can assist him mightily in keeping concise

and accurate records. It will reduce the size of the record and permit easier study of a patient history. Further, there is a lesser chance the records will be misunderstood if it becomes necessary for them to be reviewed by another person.

The AMA/CPT code will apply to all medical service which needs identification as to diagnostic procedure and treatment. It will expedite the filing of insurance claims. It is the kind of universal language that, if used widely, will reduce clarifying correspondence and make the whole process of claims filing and reimbursement more accurate and more rapid.

The Iowa Medical Society is encouraging insurance companies, governmental agencies, carriers, etc., to adopt the AMA/CPT. In this regard, the Society is pleased to have the support of Iowa Blue Shield in its campaign to obtain full acceptance of the AMA/CPT. Blue Shield has acknowledged the potential benefit likely to accrue from broad use of the AMA/CPT. Blue Shield has joined the IMS to initiate an educational program to encourage physician use in Iowa of this uniform nomenclature and coding system. Blue Shield officials have indicated they feel the cost of converting certain existing facets of their program to a five-digit system is justified when the long-term benefits are considered.

How is the AMA/CPT arranged?

In the Physician's current procedural terminology, procedures are listed under five headings: Medicine, Surgery, Radiology, Pathology and Laboratory, and Anesthesiology. In each section are subections with anatomic, procedural and other subheadings. The procedures and their services, with identifying codes, are presented in numerical order.

For instance, closed manipulative reduction of a tibia, shaft fracture closed will be found in the section *Musculoskeletal System*, anatomic sub-

(Please turn to page 334)

# IN THE PUBLIC INTEREST



When the allergic patient has a condition requiring an analgesic, a new problem arises. "Idiosyncrasy to salicylates is not rare and is usually manifested by skin rashes and anaphylactoid reaction. Sensitivity to these drugs occurs more frequently in patients with asthma and allergy." Moreover, the previous ingestion of aspirin without ill effects is no guarantee that subsequent use will not precipitate a severe reaction.<sup>2</sup>

TYLENOL (acetaminophen), on the other hand, presents little risk of allergic reaction, even in patients sensitive to aspirin,3 making it the preferred analgesic for the allergic patient.

This is only one of several 'types for TYLENOL—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Modell, W., ed.: Drugs of Choice 1970-1971, St. Louis, The C. V. Mosby Company, 1970, p. 196. 2. Goodman, L. S., and Gilman, A., ed.: The Pharmacologic Basis of Therapeutics, ed. 4. New York, The Macmillan Company, 1970, p. 327. 3. Maslansky, L., Paper delivered at Fourth International Congress of Allergology, New York, Oct. 18, 1961: abstracted Excerpta Med. Internat. Congress Series, No. 42, p. 124

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should

be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg. For Children:

Elixir, 120 mg./5cc. (alcohol 7%). Drops, 60 mg./0.6cc. (alcohol 7%). Chewable Tablets, 120 mg.

Safer than aspirin, yet just as effective for relief of pain and fever

(acetaminophen)

#### COUNTY SOCIETY OFFICERS

	RESIDENT	SECRETARY	DEPUTY COUNCILOR
Adair         A.           Adams         C.           Allamakee         A.           Appanoose         M.           Audubon         H.           Benton         S.           Black Hawk         L.           Boone         R.           Bremer         G.           Buchanan         P.           Buena Vista         E.           Butler         B.           Calhoun         W.           Carroll         D.           Cass         T.           Cedar         G.           Cerro Gordo         H.           Cherokee         D.           Chickasaw         J.	J. Gantz, Greenfield L. Bain, Corning F. Wiley, Waukon G. Parks, Centerville K. Merselis, Audubon L. Anthony, Vinton B. Harned, Waterloo E. Vermillion, D.O., Ogden J. Kimball, Waverly J. Leehey, Independence C. Laird, Storm Lake V. Andersen, Greene A. McCrary, Lake City M. McCoy, Carroll J. Payne, Atlantic H. Utley, Clarence L. Brenton, Mason City C. Koser, Cherokee C. Carr, New Hampton	A. J. Gantz, Greenfield J. C. Nolan, Corning M. F. Kiesau, Postville A. S. Owca, Centerville J. E. Ankeny, D.O. Exira W. H. Steinbeck, Keystone D. E. Conklin, Waterloo J. F. Murphy, Boone W. E. Hall, Waverly R. R. Reick, Independence G. C. Olson, Storm Lake F. F. McKean, Allison J. C. Comstock, Lake City Eleanor Roverud, Carroll D. E. Wilcox, Atlantic O. E. Kruse, Tipton J. H. Brinkman, Mason City J. N. Harten, Cherokee D. P. Schmidt, D.O., New Hamptor E. E. Lauvstad, Osceola M. L. Gannon, Spencer E. M. Downey, Guttenberg D. G. Wulf, Clinton M. U. Broers, Schleswig K. M. Chapler, Dexter J. R. Scheibe, Bloomfield E. E. Gamet, Lamoni	A. J. Gantz, Greenfield J. C. Nolan, Corning C. R. Rominger, Waukon S. S. Jewett, Centerville H. K. Merselis, Audubon D. C. Weideman, Vinton R. L. Hadlund, Waterloo J. R. Anderson, Boone R. E. Shaw, Waverly P. J. Leehey, Independence R. R. Hansen, Storm Lake F. F. McKean, Allison R. P. Ferguson, Lake City J. M. Tierney, Carroll K. R. Swanson, Atlantic G. H. Utley, Clarence W. C. Rosenfeld, Mason City H. J. Fishman, Cherokee
CrawfordR. Dallas-GuthrieD.	L. Bendixen, Denison W. Todd, Guthrie Center	M. U. Broers, Schleswig K. M. Chapler, Dexter	C. H. Fee, Denison
Delaware H. Des Moines-Louisa H.  Dickinson M. Dubuque R. Emmet L.	M. Andersen, Strawberry Point B. Tjaden, Burlington W. Kirlin, Spirit Lake H. Lee, Dubuque T. Donovan, Estherville	.W. J. Willett, Manchester	J. E. Tyrrell, Manchester J. E. Tyrrell, Manchester R. B. Allen, Burlington (D) L. E. Weber, Jr., Wapello (L) J. F. Rodawig, Jr., Spirit Lake J. S. Chapman, Dubuque
Floyd	H. Huber, Charles City W. Taylor, Sheffield M. Ashler, Hamburg F. Canady, Jefferson H. Verduyn, Reinbeck A. Paschal Webster City	J. C. Weibel, D.O., West Union D. L. Trefz, Charles City R. E. Munns, Hampton A. R. Wanamaker, Hamburg A. A. Knosp, Jefferson G. D. Button, Conrad Eduardo Reveiz, Webster City L. W. Eller, Kanawha	E. V. Ayers. Charles City F. M. Ashler, Hamburg R. W. Burke, Jefferson J. E. Rose, Grundy Center
Hancock-WinnebagoN.	D. Thede, Britt	L. W. Eller, Kanawha	J. R. Camp, Britt (H) J. T. Mangan, Forest City (W)
Hardin D. Harrison F. Henry W. Howard D. Humboldt J. Ida E. Iowa L.	E. Boldt, Ackley X. Tamisiea, Missouri Valley B. Scott, Mount Pleasant O. Maland, Cresco H. Coddington, Humboldt J. Stine, Jr., Ida Grove D. Caraway. Amana	.H. O. Stoutland, Ackley .R. G. Wilson, Missouri Valley .B. R. Nordyke, Winfield .F. L. Klingle, Jr., Cresco .M. L. Northup, Humboldt .J. B. Dressler, Ida Grove .Virginia Moldenhauer, Marengo	···A. C. Bergstrom, Missouri Valley ···J. S. Jackson, Mount Pleasant ···P. A. Nierling, Cresco
Jackson         P.           Jasper         J.           Jefferson         J.           Johnson         D.           Jones         O.           Keokuk         M           Kossuth         J.           Lee         J.	L. Gjerstad, Maquoketa W. Ferguson, Newton N. Morgan, Fairfield A. Culp, Iowa City E. Senft, Monticello L. McClenahan, Sigourney M. Rooney, Algona E. McGee, Fort Madison	C. A. Rose, D.O., Maquoketa T. E. Kiernan, Newton T. R. Wolf, D.O., Richland T. R. Nicknish, Iowa City J. J. Randolph, Monticello Puangtong Jutabha, Sigourney D. L. Bray, Algona R. L. Kent, Fort Madison	J. A. Broman, MaquoketaJ. W. Ferguson, NewtonJ. W. Castell, FairfieldG. W. Howe, Iowa CityE. H. DeShaw, MonticelloOpas Jutabha, SigourneyM. G. Bourne, AlgonaG. H. Ashline, Keokuk G. C. McGinnis, Fort Madison
LucasR.	E. Anderson, Chariton	.R. L. Sedlacek, Cedar Rapids R. E. Anderson, Chariton H. H. Gessford, George E. G. Rozeboom, Winterset Ellis Duncan, Fremont	
Marion         P.           Marshall         D.           Mitchell         T.           Monona         L.           Monona         H.	C. Todd, Knoxville J. Sullivan, Marshalltown L. Place, Osage A. Gaukel, Onawa	H. H. Gesstord, George E. G. Rozeboom, Winterset Ellis Duncan, Fremont J. M. Dockum, D.O., Monroe D. E. Tyler, Marshalltown R. G. Boeke, Osage W. P. Garred, Onawa D. N. Orelup, Albia S. R. Smith, Red Oak K. E. Wilcox, Muscatine	J. E. Griffin, KnoxvilleR. C. Carpenter, MarshalltownL. A. Gaukel, Onawa
MontgomeryG. Muscatine	M. Skallerup, Red Oak L. Parks Muscatine	S. R. Smith, Red Oak  K. E. Wilcox, Muscatine	Oscar Alden, Red Oak
O'Brien         R.           Osceola         B.           Page         G.           Palo Alto         W.           Plymouth         R.           Pocahortas         J.	E. Griffin, Sheldon  C. Miller, Clarinda  J. Morrison, D.O., West Bend  J. Fisch, LeMars  M. Rhodes, Sr., Pocahontas	. A. D. Smith, Primghar  . K. V. Jensen, Clarinda  . J. L. Coffey Emmetsburg  . S. E. Lindell, LeMars  . J. M. Rhodes, Jr., Pocahontas	E. B. Getty, PrimgharK. J. Gee, ShenandoahJ. L. Coffey, EmmetsburgL. A. George, RemsenJ. M. Rhodes, Sr., Pocahontas
Pottawattamie-MillsR.	E. Joranson, Council Bluffs	D. L. Sweem, Des Moines D. O. Minchin, Council Bluffs	M. E. Olsen, Minden (P) R. K. Fryzek, Glenwood (M)
Sac         J.           Scott         J.           Shelby         L.           Sioux         Re           Story         D.           Tama         C.           Union-Taylor         H.           Van Buren         Ki           Wanello         J.	J. Bishop, Davenport V. Larsen, Harlan Luben Samani, Sioux Center C. Anderson, Ames W. Maplethorpe, Toledo G. Beatty, Creston Lyoshi Furumoto, Keosauqua E. Rawis, Ottumwa	K. W. Caldwell, MontezumaA. R. Swearingen, BettendorfR. D. Harris, HarlanP. W. Vander Kooi, Orange City T. J. Dry, AmesA. J. Havlik, TamaJ. B. Gault, CrestonJ. T. Worrell, KeosauquaR. P. Meyers, Ottumwa	S. D. Porter, GrinnellErling Larson, Jr., DavenportJ. H. Spearing, HarlanE. B. Grossman, Jr., Orange CityW. R. Bliss, AmesA. J. Havlik, TamaD. L. York, Creston (U) R. W. Boulden, Lenox (T)Kiyoshi Furumoto, Keosauqua
Warren Ai Washington D. Wayne T. Webster M. Winneshiek I. Woodbury J.	nalgamated with Polk County G. Sattler, Kalona W. Davis, Corydon E. Kraushaar, Fort Dodge F. Greene, Decorah Tiedeman, Sjoux City	K. J. Marshall, Washington K. A. Garber, Corydon J. R. McNiel, Fort Dodge C. F. McClure, Decorah J. L. Wiedemeier, Sioux City B. H. Osten, Northwood C. P. Hawkins, Clarion	  E. F. Hagen, Decorah C. L. Beye. Sioux City

## OFFICIAL PROCEEDINGS

# 1974 HOUSE OF DELEGATES **MAY 11-13, 1974 DES MOINES, IOWA**

(Alphabetical Index—Page 335)

SATURDAY SESSION, MAY 11, 1974

The House of Delegates of the Iowa Medical Society was called to order by the Speaker, L. D. Caraway, M.D., of Amana, at 2:10 p.m., Saturday, May 11. The House approved the taking of attendance by signed registration cards. There were 110 delegates, nine voting alternates and 16 ex-officio members present.

COUNTY	DELEGATE	COUNTY	DELEGATE	COUNTY	DELEGATE
Boone Bremer Buena Vista Calhoun Cass Cerro Gordo  Cherokee Clarke Clay Clayton Clinton Crawford Dallas-Guthrie Davis Decatur-Ringgold Delaware Des Moines-Louisa Dickinson Dubuque	A. S. Owca G. R. Clark R. S. Gerard A. M. Dolan* R. R. Roth A. W. Woodward M. N. Williams R. E. Hedican, Jr. A. C. Smith E. E. Linder V. H. Carstensen E. C. Laird C. R. Wilson* T. J. Payne R. M. Powell D. D. Van Etten R. E. McCoy G. H. West, Jr. G. E. Michel J. D. Kimball J. X. Tamisiea J. D. Compton G. L. York D. J. Soll E. E. Lister N. L. Krueger H. M. Perry E. E. Gamet D. E. Mitchell J. E. Mitchell J. E. Mitchell J. E. Mitchell J. E. Gamet D. E. Mitchell J. E. Tyrrell	Hancock-Winnebag Hardin Iowa Jasper Johnson  Jones Kossuth Lee Linn  Mahaska Marshall  Monona Montgomery Muscatine O'Brien Page Plymouth Pocahontas Polk		Pottawattamie- Mills  Poweshiek Scott  Shelby Sioux Story Tama Union-Taylor Wapello Wayne Webster	J. J. Kelso L. O. Ely* R. C. Smith D. C. Young R. W. Overton E. J. Laing* A. N. Smith C. H. Denser, Jr.* D. L. Sweem D. O. Newland J. W. Green, Jr. Marshall Flapan  J. L. Knott M. E. Olsen G. L. Neligh R. K. Fryzek H. R. Light J. C. Barker A. W. Boone J. F. Collins J. C. Donahue W. B. Hofmann Erling Larson, Jr.* J. H. Spearing E. B. Grossmann, Jr. W. R. Bliss W. A. Baird A. J. Havlik R. H. Kuhl L. E. Coppoc K. A. Garber H. H. Kersten J. F. Kelly
Franklin Grundy	R. E. Munns D. R. Kruschwitz		D. J. Walter L. H. Fingerman* W. R. Hornaday, Jr. J. L. Fatland	Winneshiek Woodbury	T. F. Dynes H. N. Hirsch C. T. Helseth P. M. Cmeyla
* Alternate			M. E. Thoman	Wright	C. P. Hawkins

<sup>\*</sup> Alternate

#### LIAISON DELEGATES

S. P. Leinbach C. V

C. W. Seibert

#### EX-OFFICIO MEMBERS OF THE HOUSE

R. H. Flocks
R. L. Wicks
L. W. Swanson
R. M. Chapman
V. L. Schlaser
T. A. Burcham
J. F. Bishop
J. H. Kelley
J. W. Eckstein
H. J. Caraway
L. W. Swanson
H. J. Smith
J. R. Anderson
J. R. Anderson
J. K. E. Lister
J. W. Eckstein
J. H. Sunderbruch

V. L. Schlaser, M.D., Secretary of the Society, moved that the minutes of the October 14, 1973 session of the House of Delegates be approved as published in the December, 1973 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY. The motion passed.

Dr. Caraway introduced the individuals at the head table and welcomed 44 new voting Delegates to the

House. He directed attention to the "Working Procedures for House of Delegates," in the Delegates' packets; stressed the responsibility of delegates to their constituents, announced reference committee appointees, and noted the work load of reference committees.

Reports in the 1974 Handbook for the house of delegates were approved as published. Dr. Caraway introduced L. Neil Sutherland, Assistant Director, Public Affairs Division of AMA, Douglas Hiza, President pro tem of the Student Medical Society, and Wayne Christenson, President of the Iowa Chapter of the Student American Medical Association. Next, Dr. Caraway introduced E. B. Howard, M.D., Executive Vice President of the AMA. Dr. Howard greeted the delegates and announced he would discuss issues confronting the medical profession following the banquet on Sunday evening.

(Following are the reports previously published in the 1974 HANDBOOK FOR THE HOUSE OF DELEGATES.)

# Reports of Officers

#### FROM THE OFFICE OF THE SECRETARY

The Secretary of the Iowa Medical Society is responsible for maintaining membership and dues records; conducting the official correspondence, notifying members of meetings, officers of their election, and committee members of their appointments and duties; and preparing minutes of all official meetings. Assistance is also provided to the district councilors in organizing and improving the component societies, and in extending the usefulness of the IMS.

#### HOUSE OF DELEGATES

Proceedings of the 1973 Annual Meeting of the House of Delegates were published in the July, 1973 issue of the IMS JOURNAL. In addition, a Regular Meeting of the House of Delegates was held in October, 1973, as provided for in the amended Articles of Incorporation and By-Laws. Proceedings of this session were published in the December, 1973 IMS JOURNAL. The necessary administrative procedures have occurred to implement the directives of the delegates.

District Councilors have received assistance from IMS staff in organizing their caucuses in preparation for the 1974 Annual Meeting and in preparing for the meeting of the Nominating Committee scheduled in March.

#### ANNUAL SCIENTIFIC PROGRAM

The 1974 Annual Scientific Program will be in Iowa City, April 18, 19 and 20. The full program was published in the March issue of the IMS JOURNAL. Over 50 University of Iowa College of Medicine faculty members will participate, along with several outstanding guest speakers. The program has been approved for 10 prescribed hours by the American Academy of Family Physicians.

#### EXECUTIVE COUNCIL

Two meetings of the Executive Council have been held since the final session of the House of Delegates in 1973. The Council is the interim policy-making body which meets between sessions of the House to act on important issues. The Executive Council is scheduled to meet in April immediately preceding the Annual Scientific Session in Iowa City.

#### JUDICIAL COUNCIL

The Judicial Council has met three times in the past year, and a fourth session is scheduled in May. Whenever possible, the Board of Trustees and Judicial Council arrange a joint dinner prior to Executive Council sessions so that topics of general interest and concern can be discussed.

The principal responsibilities of the Judicial Council are (1) to approve applications for IMS membership; (2) to consider various questions regarding membership or ethics; and (3) if necessary, to discipline members of the Society.

A report from the Judicial Council appears elsewhere in the Handbook.

#### BOARD OF TRUSTEES

Regular meetings of the Board of Trustees are held monthly and special meetings are called as necessary. The Board is responsible for conducting the business of the Society and there is almost daily communication between IMS staff members and the Chairman of the Board and/or other IMS officers.

#### COMMITTEES

There are 21 standing and 32 special committees of the IMS. Over 40 official meetings have been held since the House of Delegates adjourned its final session last April. Many committees are scheduled to meet prior to the opening session of the 1974 House of Delegates.

In addition to formal committee work, staff members maintain regular contact with committee chairmen and members by telephone and personal visitation to carry out specific projects and activities.

The Society is represented on councils and committees of various state and voluntary agencies, e.g., the Iowa Regional Advisory Group, the Advisory Council to the Office for Comprehensive Health Planning, Advisory Committee on Emergency Medical Services, Advisory Committee on Physicians' Assistants Program, the Iowa Health Council, the Inter-Agency Smoking Committee, Advisory Council on Family Practice Residencies, State Drug Abuse Advisory Council, Commission to Study Nursing in Iowa, etc.

#### NATIONAL, REGIONAL AND STATE CONFERENCES

The trustees have been selective in authorizing IMS representation at national, regional and state conferences. The Trustees believe gathering and exchanging information on medical programs and issues are important and beneficial to the Society. Following is a partial listing of the major conferences at which the IMS was represented this past year: American Medical Association-Annual and Clinical Meetings; PSRO Conference; Conference on Physicians and Schools; Leadership Conference; Congress on Medical Education; Medicine and Religion Conference; AMPAC Public Affairs Workshop; Rural Health Conference; National Blue Shield Annual Meeting; Blue Shield Board of Directors Meetings; North Central Medical Conference; SMJAB Conference; Iowa Health Council Leadership Conference; Statewide Conference on Emergency Medical Service.

#### IOWA REPRESENTATION AT THE NATIONAL LEVEL

Close liaison between the IMS and AMA is maintained at both the officer and staff level. Several IMS members serve on AMA Councils and Committees, including the following: D. F. Ward, M.D., Dubuque, Council on Legislation; C. H. Denser, Jr., M.D., Des Moines, Committee on Quackery; B. F. McCabe, M.D., Iowa City, Residency Review Committee-Urology and Interspecialty Council; George Penick, M.D., Iowa City, Archives of Pathology; Craig Ellyson, M.D., Waterloo, Joint Commission on Health Problems in Education of NEA and AMA; Roger Simpson, M.D., Iowa City, Interspecialty Council, American Academy of Otolaryngology; Maurice Van Allen, M.D., Iowa City, Interspecialty Council, American Academy of Neurology; Scientific Section Council Officers-Paul Seebohm, M.D., Iowa City, American Academy of Allergy; Carl Graf, M.D., Iowa City, American Association of Neurological Surgeons; David Culp, M.D., Iowa City, American Urological Association.

Donald L. Taylor, IMS Executive Vice President, a past-president of the American Association of Medical Society Executives, and three other IMS staff members are active in the AAMSE organization. Mr. Taylor just completed a term on a special Advisory Committee to the AMA Executive Vice President; is a member of the American Association of Foundations for Medical Care (AAFMC) Task Force to Department of HEW on Professional Standards Review Organizations (PSRO); is a member of AMA Ad Hoc Committee on Federal-State Legislation; and was recently elected Second Vice President of the Professional Convention Management Association. Tina Preftakes serves on the 1973-1974 Nominating Committee of AAMSE.

#### IMS FIELD SERVICE

Mr. Eldon Huston, Assistant Executive Vice President, directs the Provider Service Division of Blue Cross/Blue Shield, which includes both hospital and physician relations. This division includes six physician relations representatives who maintain personal contact with physicians throughout the state and provide a valuable service to them, as well as to organized medicine and Blue Shield. The representatives operate in designated regions, and according to comments from physicians, they function effectively and provide valuable information and assistance.

#### COMMUNICATIONS

The Iowa Medical Society uses various methods to maintain contact with the membership and to apprise Iowa physicians (1) of the many projects and programs

- undertaken by the Society, and (2) of its position on the numerous issues which confront medicine. Following is a listing of communications published and/or distributed through the Society to inform the membership of what is occurring in organized medicine:
- 1. IMS JOURNAL—to all members; subscribers; clinical departments at The University of Iowa College of Medicine as a reference for residents, interns and medical students; also, exchange copies with other medical journals.
- 2. IMS NEWS BULLETIN—to all members, plus a selected group of allied health representatives. Bulletins reporting on IMS and AMA annual meetings are sent to all medical students at the University of Iowa College of Medicine.
- 3. LEGISLATIVE BULLETIN—to L.C.M.'s, Legislative Committee members, Executive Council, IMPAC Board of Directors, county society presidents, various allied health personnel, and to all IMS members when appropriate.
- 4. IMS REPORT—to all state and county medical society officers; to all medical students at the University of Iowa College of Medicine; to all of the previous year's graduates who are interning in various hospitals throughout the country.
- 5. IN THE PUBLIC INTEREST—reprints to all members of the Iowa Press and Iowa Daily Press Associations; all members of the Iowa General Assembly; members of the IMS Woman's Auxiliary.
- 6. WOMAN'S AUXILIARY NEWS—to all members of the IMS Woman's Auxiliary and officers of the Society.
- 7. AMERICAN MEDICAL NEWS—to all members of the Iowa General Assembly.
- 8. AMA EXECUTIVE VICE PRESIDENT'S LETTER—to all members of the Executive Council.

#### IMS MEMBERSHIP

Iowa Medical Society membership for 1973 totaled 2,323. Of this number, 153 held active dues-exempt membership (101 life members, 50 residents, and 2 members in military service), and 78 associate members were exempt from the payment of dues. There were 48 counties (in 46 single or two-county societies) in which 100 per cent of the county society members held membership in the IMS. Physicians ineligible for membership numbered 79, and there were 268 eligible non-members in Iowa. The number of retired or not-in-practice physicians was 45. The percentage of eligible physicians who held IMS memberships was 90 for the year.

### COUNTY SOCIETIES HAVING 100 PER CENT MEMBERSHIP IN IMS IN 1973

Delaware	Monona
Emmet	$\mathbf{Monroe}$
Franklin	Montgomery
Fremont	O'Brien
Grundy	Plymouth
Hamilton	Pocahontas
Hardin	Shelby
Harrison	Sioux
Ida	Tama
Jefferson	Union-Taylor
Jones	Van Buren
Keokuk	Wayne
Kossuth	Webster
Lucas	Winneshiek
Madison	Wright
Mitchell	
	Emmet Franklin Fremont Grundy Hamilton Hardin Harrison Ida Jefferson Jones Keokuk Kossuth Lucas Madison

#### 1973 IMS MEMBERSHIP RECORD

County	Active Members	Associate Members	Eligible Non-Members	Ineligible Non-Members	Not in Practice or Retired	Percentage	County	Active Members	Associate Members	Eligible Non-Members	Ineligible Non-Members	Not in Practice or Retired	
A 3 = i =							T						
Adair	$\frac{1}{2}$		• •	• •	1	$\begin{array}{c} 100 \\ 100 \end{array}$	Jasper Jefferson	15 11	1 1	1	• •	1	
Allamakee	8		i		• •	89	Johnson	287		57	50		
Appanoose	7	i				100	Jones	9	• •			í	
Audubon	3				• •	100	Keokuk	5	2		• •		
Benton	7	• •			• •	70	Kossuth	9	ĩ		• •		
Black Hawk	126	5	4			97	Lee	38	2	1			
Boone	15	2				100	Linn	140	10	21		2	
Bremer	12	ĩ			• •	100	Lucas	3					
Buchanan	16		5	2	i	76	Lyon	4	i	i			
Buena Vista	11					100	Madison	3					
Butler	6					100	Mahaska	18		i			
Calhoun	9		1		1	90	Marion	12		3	9	3	
Carroll	19	1	3			87	Marshall	44		2		2	
ass	11		1			92	Mitchell	11	1				
edar	4				i	100	Monona	7				1	
Cerro Gordo	73	2			1	100	Monroe	3					
herokee	18		7		1	72	Montgomery	11					
hickasaw	5	1				100	Muscatine	11	2	2	1		
Clarke	6					100	O'Brien	11					
lay	11					100	Osceola			4			
Clayton	7	1	1		1	89	Page	20		2		1	
Clinton	26	1	18	1	1	60	Palo Alto	7		1			
Crawford	8		2			80	Plymouth	10					
Dallas-Guthrie	16	1	5	3		78	Pocahontas	6				1	
Davis	16					100	Polk	325	17	33	4	2	
Decatur-Ringgold	7					100	Pottawattamie-Mills	67	1	5	2	3	
Delaware	7					100	Poweshiek	8		3			
Des Moines-Louisa	45	1	7		1	87			• •	6	• •	• •	
Dickinson	7	1	1		1	89	Sac	111		9		1	
Dubuque	52	1	27			66	Scott	111	1	9	1		
Emmet	13					100	Shelby	10	• •	• •	• •	1	
Fayette	12	2	4			78	Sioux	11	• • •	• :	• :	• •	
Floyd	14		2			88	Story	59	4	5	1	• •	
Franklin	4			1		100	Tama	6	• •	• •		• •	
Fremont	5					100	Union-Taylor	14			• •		
Greene	8		1			89	Van Buren	2					
Grundy	6	• •				100	Wapello	38	1	1		2	
Hamilton	6	2		• •	• :	100	Warren amalgamated with Po	olk					
Hancock-Winnebago	9	• •	3	1	1	75	Washington	7		1			
Hardin	11	1				100	Wayne	2				1	
Harrison	8		• •		• •	100	Webster	54				2	
Henry	11		2	3		85	Winneshiek	14	1				
Howard	7	1	1			89	Woodbury	107	5	5		4	
Humboldt	4	2	1		• •	86	Worth	3		ĭ			
Ida	2		• :	• •	1	100	Wright	15					
Iowa	7		1		• •	88		$\frac{15}{2.245}$	78	268	79	45	
Jackson	9		2			82	TOTALS	2,243	10	200	19	40	

Fixed Assets:

#### REPORT OF THE TREASURER

The following financial statements reflect the fiscal status of the Iowa Medical Society as of December 31, 1973. The 1973 income exceeded expenses by \$21,592.01.

#### IOWA MEDICAL SOCIETY Balance Sheet—December 31, 1973

#### ASSETS

Current Assets:	
IMS Checking Accounts	\$ 24,041.81
Pension and Disability Insurance—	
Due from Employees	358.84
Investments	61,730.13
Short Term Investments	80,000.00
Accounts Receivable	6,250.00
Prepaid Expenses	2,200.00
TOTAL CURRENT ASSETS	\$174,580.78

Land	\$ 74,216.96
Building \$308,264.76	. ,
Office Furniture & Equipment 38,539.78	
Less: Reserve for Depreciation \$203,565.00	\$143,239.54
Net Fixed Assets	\$217.456.50
TOTAL ASSETS	\$392,037.28
Liabilities and Net Worth	
Liabilities:	
Accrued Personal & Property Tax	\$ 14,000.00
Deferred Compensation	61,730.13
Due to Employees	41.03
Deferred Income	
TOTAL LIABILITIES	\$266,371.16
Net Worth:	
Balance 1-1-73 \$104,074.11	
Add: Net Excess of Income	
over Expenses	
Balance Net Worth	\$125,666.12
TOTAL LIABILITIES AND NET WORTH	\$392,037.28

#### IOWA MEDICAL SOCIETY STATEMENT OF INCOME AND EXPENSES For the Year Ended December 31, 1973

Income for the Year 1973:	
Dues—State Society	\$310,425.00
Interest on Investments	2,551.75
Miscellaneous	676.93
AMA Collection Commission	2,151.75
Building Rental & Services	4,800.00
Gain on Sale of Stock	850.68
TOTAL INCOME	\$321,456.11
Expenses for the Year 1973:	T,
Annual Scientific Meeting (Net)	\$ 2,143,14
Council Expense	1,952.43
County Society Services	3,768.77
Dues and Subscriptions	2,358.25
Employee Pension, Disability &	_,
Health Program	16,298.83
Field Service	14,733.08
General Administrative Expense	3,129.40
House of Delegates	5,209.93
Insurance	2,927.53
Interest Expense	847.50
Journal (Net)	17,500.97
Legal Expense	6,146,90
Lights, Gas & Water	6,501.61
Office Stationery & Supplies	7,395.35
Postage	7,010.67
Repairs & Maintenance	7,705.36
Salaries	111,113.77
Service Contracts—Machines	1,335.23
Taxes:	ŕ
Personal & Property	12,643.68
Social Security/Unemployment	7,481.18
Telephone & Telegraph	9,003.18
Travel—Officers	10,716.50
Travel—Salaried Employees	11,470.97
Trustee Expense	3,188.98
Woman's Auxiliary	6,031.25
Committee Expense	25,535.92
TOTAL EXPENSE	\$299,864.10
Net Excess of Income over Expenses	φ200,004.10
for 1973	\$ 21 592 01
Thomas A. Burcham, M.D., 7	
THOMAS A. DURCHAM, MI.D., 1	reasurer

#### **BOARD OF TRUSTEES REPORT**

A detailed and up-to-date accounting of the Society's finances and activities will be presented at the 1974 Annual Meeting of the House of Delegates in a special supplemental report. An interim accounting was presented by the Board of Trustees to the House of Delegates at its Regular Meeting in October 1973.

The Board of Trustees meets on a regular monthly basis in order to take action on and oversee the numerous and varied projects of the Iowa Medical Society.

J. F. BISHOP, M.D., Chairman

#### REPORT OF THE JUDICIAL COUNCIL

The Judicial Council continues to meet quarterly to consider membership matters and related ethical questions. The 12 councilors function as "peace-makers" within their respective districts. Most of the items referred to the Council derive from a lack of information on the part of the inquiring physician and these are normally resolved quickly when the Judicial Council or individual councilor has an opportunity to explain the matter.

The Judicial Council spent much time and effort this past year co-ordinating a membership information program. The program was successful, but the Council is seeking an even higher percentage of eligible physicians as members of the Iowa Medical Society. The Council regards the Society as the most appropriate voice for Iowa physicians on the scientific and socio-economic aspects of medical care.

This past year the councilors organized and distributed information on the apportionment of the House of Delegates. This was an important part of the effort which preceded action by the House of Delegates in October, 1973 which altered the delegate/member ratio.

The Judicial Council will have one additional meeting prior to the 1974 House of Delegates session. If items are considered which need House attention, they will be included in a supplemental report.

E. E. GAMET, M.D., Chairman

#### Reports of Standing Committees

# COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

In October 1973, the House of Delegates considered a comprehensive report from the Committee on Articles of Incorporation and By-Laws. This report contained recommendations on several matters referred to the Committee by the House. At the October meeting, the House acted on the Committee's recommendations and the Articles and By-Laws have been amended in several respects, with perhaps the most far reaching action being the change in the make-up of the House of Delegates. The House changed the formula for House representation from one delegate for each 25 members or major fraction thereof, to one delegate for each 15 members or major fraction thereof. In taking this action the House retained the right of every component society to be represented by at least one delegate.

Between now and the time of the Annual Meeting of the House of Delegates, it is likely there will be one or two items that will require the attention of the Committee.

K. J. JUDIESCH, M.D., Chairman

#### GRIEVANCE COMMITTEE

The Committee met at irregular intervals in 1973. A total of 10 cases were reviewed and settled. Many of the problems involved interprofessional and intraprofessional relationships. The number of cases is the smallest we have had for several years.

S. E. ZIFFREN, M.D., Chairman

#### COMMITTEE ON HEALTH EDUCATION

No special projects have been undertaken by the Health Education Committee this year, but it is important to note some of our continuing activities.

The IMS is in its sixteenth year of participation in a weekly health education radio program broadcast over WOI in Ames. Physicians from all areas of the state are interviewed on a variety of health topics.

Requests from lay and professional groups for speakers and films on health subjects are also handled by the IMS, and the Society also responds to many requests from students for informational articles and brochures dealing with health and medical problems.

A member of the Committee, C. D. Ellyson, M.D., has

been privileged to represent the IMS on the Joint Committee on Health Problems in Education of the American Medical Association and National Education Association. This is a coordinating and liaison body which affords medicine and education an opportunity to confer on matters related to the health of children and youth. It reviews problems with medical and educational implications, and its pronouncements and resolutions have been used effectively in guiding school health programs.

The Society has been represented at two "Quality of Life" conferences sponsored by the AMA, and a third is to be held in Chicago, April 1-3. It is likely a similar conference, dealing with improving the health and the quality of life of Iowans, will be arranged sometime in the future.

The Committee is available to assist any county medical society in the development of special health education programs designed for schools, or for the mass communications media.

L. J. KIRKHAM, M.D., Chairman

#### NECROLOGY COMMITTEE

The following members of the Iowa Medical Society died during 1973:

	$Ag\epsilon$
Angelo B. Barbieri, Marshalltown	. 72
Milford E. Barnes, Iowa City	. 89
Maurice T. Bates, Des Moines	. 69
Martin A. Blackstone, Sioux City	. 66
George A. Blaha, Whitten	. 84
George B. Bristow, Osceola	. 49
William B. Chase, Jr., Des Moines	. 66
Stuart H. Cook, Rock Rapids	. 72
Francis X. Cretzmeyer, Iowa City	. 91
Kenneth R. Cross, Iowa City	. 58
Vernon S. Downs, Ottumwa	. 7€
Dean E. Finken, Logan	. 41
Morgan J. Foster, Cedar Rapids	. 75
Robert D. Gauchat, Iowa City	. 50
George M. Gibbs, Burlington	. 73
Arnold M. Gordon, Des Moines	. 70
Nelson L. Hersey, Independence	. 75
Louis H. Kornder, Davenport	. 85
Frank D. Lawson, Fort Dodge	. 41
John I. Marker, Davenport	. 84
George E. Morrissey, Davenport	
Frederick W. Mulsow, Cedar Rapids	91
James E. Murtaugh, New Hampton	68
Dennis R. Olson, New Hampton	. 38
Ralph T. Paige, LaPorte City	
Jerome F. Paulson, Mason City	. 58
Allan B. Phillips, Des Moines	63
Norman A. Schacht, Fort Dodge	. 51
Rome L. Schaffner, Cedar Rapids	47
Rutledge C. Schropp, Des Moines	
J. Ned Smith, Iowa City	. 83
Thomas F. Suchomel, Cedar Rapids	
John C. Teufel, Davenport	. 92
Colin G. Thomas, Monticello	. 85
James H. Turner, Fairfield	
Ingmar U. Vangsness, Largo, Florida	. 85
Peter Van Zante, Pella	
Thomas S. Walker, Riceville	. 92
B. Raymond Weston, Mason City	. 79
Robert A. Wilcox, Iowa City	. 54
Albert J. Wentzien, Tama	67
Ezra L. Wurtzer, Clear Lake	84

#### COMMITTEE ON LEGISLATION

John H. Kelley, M.D., has become a member of the Board of Trustees. We are certain the leadership and dedication he demonstrated as chairman of this Committee will continue and serve him well in his new position.

There have been two major developments on the congressional scene in the realm of health care.

HMO's—The Nixon administration's HMO plan has been enacted and will provide funds for experimentation with this health care delivery approach. The federal law was written in such a way as not to override existing state HMO statutes including Iowa's recently enacted enabling legislation.

National Health Insurance—The American Medical Association Medicredit Bill now has over 180 sponsors in Congress, thus giving it more sponsors than any other proposed national health insurance plan. The President recently released his plan for a national health insurance scheme. This proposal provides for subsidies to low income citizens with a graduated scale of reimbursement for other income brackets.

In response to actions of the IMS House of Delegates taken at the April, 1973 meeting, the Committee on Legislation, with the assistance of the Board of Trustees, has made several changes in the Iowa Medical Society's legislative program. Most significant is the adoption of a priority list of bills. These measures are felt to be of primary interest to all of Iowa medicine. Five bills are on the priority list: (1) expansion of chiropractic, (2) professional and occupational licensing boards, (3) confidentiality of patients' records, (4) generic prescribing and (5) insurance coverage for chiropractic services.

These priorities are not rigid and can be modified any time new legislation arises which is of enough importance to warrant special consideration. Thus far the new program appears to be successful but it can only be as good as members of the IMS are willing to make it. The year 1974 is an election year and again we urge you to be especially active in and concerned over the political process. Grass roots support for the candidate of your choice is the most effective way of assuring legislative success.

DONALD C. YOUNG, M.D., Chairman

# COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

At the regular session of the House of Delegates last October, the Committee on Medical Education and Hospitals submitted a report on continuing medical education requirements for physicians. This report was developed in response to a legislative directive to the State Board of Medical Examiners that it and other state examining boards "submit recommendations for continuing education requirements for licensed or registered members of their occupations or professions." The House took the following action:

"Resolved that the importance and value of continuing medical education be totally and forcefully reaffirmed by the IMS;

"Resolved that the details of devising a program for documenting evidence of continuing medical education be considered jointly by the IMS, by the State Board of Medical Examiners, and by the Iowa Society of Osteopathic Physicians and Surgeons;

"Resolved that a progress report on the development of such a program be submitted, prior to the consideration of any state legislation, to either this House of Delegates or to the Executive Council." In accordance with this directive, the Committee met with representatives of the Board of Medical Examiners on November 21, 1973. Background information regarding CME developments and requirements in other states was reviewed, and there was considerable discussion on the pros and cons of establishing CME requirements for relicensure.

The Committee and the BME representatives agreed on the following general points:

1. If the Iowa General Assembly enacts legislation establishing participation in continuing education programs as a requisite for relicensure of members of the licensed professions and occupations in the state, there should be no "exempt" profession or occupation—i.e., such a requirement should be imposed on all such groups, or none.

2. If legislation is considered and enacted, it should be permissive in nature, similar to the statute adopted in the State of New Mexico, with authority granted to the Board of Medical Examiners (and other Boards) to establish specific CME requirements by rule and regulation.

3. A total of 150 hours of CME over a three-year period should be established as a minimum requirement.

4. The BME should have authority to waive CME requirements for physicians under certain situations and circumstances.

5. CME requirements should be applicable to holders of Iowa licenses residing out of state, as well as those who practice in the state.

A report on the November 21 meeting, along with a draft of a report developed by the Board of Medical Examiners for submission to the Iowa Legislature, was sent to the Executive Council on December 21, 1973.

On January 9, 1974, a comprehensive report on this subject was submitted to the Iowa General Assembly by the State Board of Medical Examiners, including the above five recommendations, and with emphasis on the fact that physicians are currently devoting an extraordinary amount of time, effort and money in the pursuit of professional education.

A verbal report on the deliberations of the Committee and the BME was presented to the Executive Council at its meeting on January 24, 1974. Copies of the BME report to the Iowa General Assembly were provided to each member of the Council. A copy is available to any interested physician. The Executive Council graciously commended the Committee for providing advice and counsel to the BME in its development of a report to the Legislature. The Council directed that the report of the Committee be filed.

The IMS will be alert to further consideration of this important matter by the Iowa Legislature. Either this Committee or the Committee on Legislation will present a progress report to the House of Delegates in May.

The Committee will maintain liaison with the BME so it can be helpful if and when the Board is directed to establish CME requirements for relicensure.

# It is our pleasure to serve as Administrators and Counselors for major Insurance Programs in behalf of the Members of many lowa Association Groups including:

- \* IOWA DENTAL ASSOCIATION
- \* IOWA ENGINEERING SOCIETY
- \* IOWA MEDICAL SOCIETY

- ★ IOWA SOCIETY OF OSTEOPATHIC PHYSICIANS AND SURGEONS
- \* IOWA STATE ASSOCIATION OF COUNTIES
- \* LEAGUE OF IOWA MUNICIPALITIES

# THE PROUTY COMPANY

Wm. R. Prouty, John A. Reno and Bernard C. Lowe, Jr., C.L.U. 2124 GRAND AVENUE/DES MOINES, IOWA 50312 (515) 243-5255 On recommendation of the Committee, the IMS served as a co-sponsor of a special conference on the use of the problem-oriented medical record system. The program, arranged by the Iowa Hospital Association, was in Des Moines on January 16 and 17 with over 500 persons in attendance, including physicians, hospital administrators, nurses, hospital medical record librarians, and other interested individuals.

H. F. Moessner, M.D., Chairman

#### COMMITTEE ON MEDICAL SERVICE

In recent years this report of the Committee on Medical Service has served to introduce the comments of three subcommittees (Economics of Health Care, Medical Review and Medical Practice in Health Facilities and Homes). The reports of these IMS components follow and members of the 1973 House of Delegates are invited to consider them.

The provision of medical service continues to increase in complexity with each passing year. Various factors offer grounds for optimism, e.g., the increasing production of medical manpower, the satisfactory progress of the Iowa Foundation for Medical Care, etc. Conversely, ominous signs cloud the horizon, e.g., PSRO, national health insurance proposals. The Society has sought to offer responsible leadership which is in the best interest of the profession and the public.

Worthy of note in this report is the release in 1973 of a new Health Insurance Claim Form developed by the American Medical Association and the Health Insurance Council in cooperation with several other organizations. The form has been devised to be universally applicable to all third-party programs, e.g., Medicare, Medicaid, CHAMPUS, Blue Shield, private insurance, etc. The ultimate goal of this joint effort is to simplify and standardize the reporting of physician services for reimbursement purposes. The claim form may be ordered from the AMA in single, two part (carbonized), and two-part continuous form for computer use.

Some progress has been made in the development of health maintenance organization capability in Iowa since the 1973 passage of enabling legislation. The HMO division of the State Department of Health has been developing rules and regulations to supplement the legislation. These are to be considered in a forthcoming public hearing. The Society is represented on a State HMO Advisory Committee to the Insurance Commissioner.

In concluding this report, it is appropriate to acknowledge the notable efforts of the Iowa Foundation for Medical Care in providing peer review service to an increasing number of acceptable third party organizations.

J. K. MACGREGOR, M.D., Chairman

# SUBCOMMITTEE ON ECONOMICS OF HEALTH CARE

The economics of health care remain unsettled with federal edicts introducing greater complexity and greater uncertainty as time passes. As this brief report is prepared, Phase 4 regulations issued by the Cost of Living Council are in a state of implementation. The COLC has rebuffed pleas from physician groups, including the American Medical Association, for an exemption from all wage and price controls for the medical profession. The AMA has filed suit to overturn the Phase 4 stipulations.

Under Phase 4 physicians are permitted an annual aggregate fee increase of 4%. A 10% maximum fee increase is allowed for specific charge items; fees under \$10 can be

raised by \$1. These limits remain legally in effect until April 30, by which time Congress must authorize an extension of the President's powers to impose wage-price controls or they will expire. There appears to be considerable congressional sentiment to terminate the program.

The Society has sought to keep member physicians informed as to the regulations contained in each of the four phases.

Also receiving much exposure in recent weeks has been the administration's national health insurance proposal. The likelihood of an NHI program seems to be increasing steadily. The AMA's Medicredit continues to have the highest number of Congressional sponsors.

The state's medical profession can take a measure of pride in the development of the Iowa Foundation for Medical Care. The efforts of the Foundation to assure quality care in appropriate amounts and at equitable costs have received much favorable comment. The Foundation now provides peer review service to virtually all insurance companies in Iowa.

It appears likely the Foundation will be named the professional standards review organization for Iowa following the state's designation as a single PSRO unit. Support for the Foundation to function in this capacity has been extensive.

Before the Subcommittee has been the matter of structuring of geographical entities within the state for purposes of fee profile construction. A re-arrangement of the regional subdivisions was proposed at one time. This possibility has been shelved in favor of one statewide customary fee determination program. In January the Executive Council sustained the action of the 1973 IMS House of Delegates and agreed that Blue Shield should move to a statewide determination of customary charges by specialty (excluding the University of Iowa) at the earliest possible date.

C. O. Adams, M.D., Chairman

#### SUBCOMMITTEE ON MEDICAL REVIEW

During the past year, the Subcommittee considered modifications in the "Standards of Medical Care" and approved several which will be included in any up-date of the "Standards." In addition, the Subcommittee reviewed one case in its capacity as a state claims review body. As the House is aware, the Iowa Foundation for Medical Care has assumed peer review activities for the Iowa Medical Society and only in rare instances will this Subcommittee serve as a claims review committee. The Subcommittee will continue to serve as a liaison body with the Iowa Foundation for Medical Care and perform other functions as instructed by the appropriate bodies of the Iowa Medical Society.

R. S. GERARD, M.D., Chairman

# SUBCOMMITTEE ON MEDICAL PRACTICE IN HEALTH FACILITIES AND HOMES

No meetings of the Subcommittee on Medical Practice in Health Facilities and Homes have been held this year.

As is customary, requests from member physicians for information on medical practice matters involving institutions have been received by the Society and answered to the fullest extent possible. These inquiries have had to do with medical staff organization, relations with hospital boards of directors, staff privileges, consent procedures and forms, etc.

Two recent articles in the Journal of the Iowa medical society fall within the subject realm of this Committee and are noted for the record: In November 1973, a discussional statement of the control of the control of the record of the record of the record.

sion was presented on the Intermediate Care Facilities Program which has been added to Title XIX. This article described what is required of physicians (1) in the initial ICFP authorization process, (2) in the periodic re-evaluation area, and (3) in the independent review phase. The State Department of Social Services has endeavored to minimize the administrative participation of the physician in this total process.

The second article appeared in the February 1974 JOURNAL as a discussion of hospital-medical staffs relationships. This paper was written by B. J. Anderson of the

AMA legal department.

Services offered by county public health nurses have increased this year. Eighty-six counties now provide public health nursing on some scale. For the fiscal year concluding June 30, 1973, according to the State Department of Health, 105,985 nursing services were provided to Iowans ill in their homes.

The number of home health agencies certified in Iowa to provide home care services under the Health Insurance Benefits Program has increased in the past year from 49 to 55.

J. F. VEVERKA, M.D., Chairman

#### MEDICO-LEGAL COMMITTEE

Professional liability coverage for physicians continues to be the principal matter before the Medico-Legal Committee. A meeting of the Committee is scheduled as this report is prepared. If significant developments occur or if recommendations are formulated at this meeting they will be transmitted to the House of Delegates in a supplemental report.

The Committee is mindful of the interest of the House and all Iowa doctors in this important topic. In 1973 the House requested it be kept informed of malpractice de-

velopments.

The services of the Society's insurance administrator have been enlisted in recent months to further survey the market and determine the merits of a Society-sponsored plan. In this way contact has either been continued or initiated with Aetna, Travelers and Hartford. An outline of the group coverage provided the Arizona Medical Association by Travelers has been received and considered. These several companies have indicated a willingness to confer with Society officials on the feasibility of a sponsored plan but they frankly have questioned both the need and their ability to be competitive with Medical Protective of Fort Wayne. Further consideration along this line is scheduled at the late-March committee meeting.

Communication has been maintained with Medical Protective's representative inasmuch as this company is the major provider of professional liability coverage to Iowa physicians. It is hoped he will be present when the Committee meets in a few weeks to relate the current experience of his company. Medical Protective has advised the Committee regularly that it has no interest in a formalized tie with the Society in the nature of a group plan. The company is now observing its 75th anniversary year by inviting its insureds to extend coverage to one million dollars.

Informal contact has been maintained with the Iowa Insurance Commissioner. It is anticipated he and/or his representatives will attend a portion of the forthcoming meeting to present information on malpractice matters from their perspective.

Under consideration is a survey of all state medical societies to determine accurately the extent to which these bodies are involved with sponsored plans. A tentative

survey has been devised requesting name of underwriter, length of time present program in effect, percentage of members covered, claim experience, premiums, etc. This survey may be a logical extension of the Committee's 1973 sampling of IMS opinion as to the merits of a group program. Fifty-six percent of the IMS respondents indicated some acceptance of the sponsored concept.

It should be noted that some states have encountered recent problems with their coverages. The most notable example is New York where Employers Insurance of Wasau has signified its intention to withdraw its coverage. Negotiations are in process to remove as much of the trauma as possible from this withdrawal action.

Specific problems of various physicians have been received and counsel has been provided as possible. Copies of the AMA booklet, "Medicolegal Forms with Legal Analysis," have been forwarded to answer several member inquiries. It should be noted however that the questions or expressions of concern over professional liability coverage from member physicians have been relatively few in number the past year.

Material has been received from the AMA which recommends study by states as to the adequacy or inadequacy of official medicolegal investigations of death. This will be given attention as possible.

It appears likely that a supplemental report to enlarge on the matters noted herein will be made to the 1974 House of Delegates.

CLARENCE H. DENSER, JR., M.D., Chairman

#### COMMITTEE ON PUBLIC RELATIONS

The Committee on Public Relations, which has been functioning on a stand-by basis, is pleased to call attention to some of the major activities and projects of the IMS which are "in the public interest" and which serve to promote better public understanding of the physician and the objectives of organized medicine: The Committee on Safe Transportation consults with officials of the Department of Public Safety to consider ways of reducing the number of motor vehicle injuries and fatalities; the Committee on Drug Abuse is engaged in several projects designed to thwart the abuse and misuse of drugs; the Committee on Sports Medicine is arranging a second conference geared to the interest of coaches, trainers, physicians, and others interested in athletic programs for students; the Alcoholism Committee supports education programs for junior and senior high school students; the IMS and other members of the Iowa Health Council hosted a dinner for members of the Iowa General Assembly and other officials of state government; the IMS took part in a series of press conferences in several Iowa cities last October to promote Immunization Month; the IMS cosponsored a series of workshops on medical care evaluation; the IMS endorsed, for the third year, the Medical Education and Community Orientation Project (MECO) of the Iowa Chapter/SAMA which puts students into community hospitals during their vacation periods to broaden their medical perspectives, and to recruit future physicians for Iowa communities.

The IMS will co-sponsor the 16th Hawkeye Science Fair in Des Moines, April 5-6, along with Drake University, the DES MOINES REGISTER AND TRIBUNE, and the Scanlon Medical Foundation/IMS. This event is high on the list of priority PR projects.

All state news outlets receive reprints of the monthly IMS JOURNAL feature titled "In the Public Interest" which comments on various issues and developments in the health field. Members of the Iowa Legislature also receive reprints for their information and resource files.

The IMS continues its involvement in a series of radio programs on health subjects broadcast over WOI-TV, Ames. Members of the Society appear on the program to answer questions on various medical and health problems.

There are continuing efforts to maintain good communications with the public and the press via the dissemination of appropriate news releases, letters-to-the-editor, and through personal contacts with representatives of the mass communications media. A year ago, the Assistant Managing Editor of the DES MOINES TRIBUNE accepted an invitation extended by the IMS to address a meeting of Iowa Health Council officials and members on the subject "Health Care in Iowa—A View of Public Attitudes and Opinions." He additionally participated in a panel discussion on "Medicine and the Press" at the 1973 North Central Medical Conference Annual Meeting in St. Paul, Minnesota.

The des moines register consulted with the IMS in the development of a survey of Iowa doctors to seek their views on "the future of medicine." The results of the survey were published in the des moines register last July and August.

The Committee encourages county medical societies and local physicians to implement projects to enhance public understanding of and support for medicine's position on the various health issues of the day.

J. G. THOMSEN, M.D., Chairman

# SUBCOMMITTEE ON INTERPROFESSIONAL ACTIVITIES

At the regular meeting of the House of Delegates in October, 1973, consideration was given to a report of the Subcommittee on Interprofessional Activities on a proposed "Pilot Pharmacy Project" submitted by Blue Cross. The project was to involve Title XIX recipients for the purpose of determining whether expanding the pharmacist's role in drug use control could result in added health benefits to the patient, as well as reduce the overall utilization and cost of pharmaceutical services.

Considerable attention was given to this proposal by the House, in a reference committee hearing and at the final House session. Considerable concern was expressed by the delegates over the proposed project, specifically (1) the provision that the pharmacist be knowledgeable regarding the patient's primary diagnosis and drug idiosyncrasies; and (2) the need for a monthly review by the pharmacist with the physician of each patient's medication history.

In light of the reaction to the proposal by the delegates, and after due deliberation, the House approved a motion that the proposed Pilot Pharmacy Project be abandoned.

The House did recognize the importance of maintaining active interprofessional communications, and urged that this activity be encouraged and maintained at the county and state levels. The Committee intends to carry out its responsibilities in this regard.

At a joint meeting of the Interprofessional Activities Committees of the IMS and the Iowa Pharmaceutical Association last August, it was announced the IPhA had approved the following recommendation in May: "(1) That the American Pharmaceutical Association be advised that the IPhA opposes the repeal of antisubstitution laws, per se, but endorses the concept of product selection by the pharmacist from among multi-source products with the knowledge and consent of the prescriber; (2) that the IPhA endorses the concept of the pharmacist's responsibility to screen every prescription and patient drug record for potential interaction and other prescribing problems,

and to seek an amended Rx when, in the professional judgment of the pharmacist, it is in the best interest therapeutically or economically of the patient; and (3) that the IPhA recommends and encourages personal interaction and consultation between pharmacists and prescribers to achieve mutual understanding and implementation of these concepts, and to obtain consent and clearly defined limits of the pharmacist's freedom and authority."

The Iowa Medical Society remains active in the Iowa Health Council, with two representatives of the Committee serving on the IHC Board of Directors (C. E. Radcliffe, M.D., and V. H. Carstensen, M.D.), and Mr. Donald Taylor, Executive Vice President, serving as Secretary-Treasurer. The IHC consists of the following member organizations: Iowa Dental Association, Iowa Hospital Association, Iowa Medical Society, Iowa Nurses' Association, Health Facilities Association of Iowa, Iowa Pharmaceutical Association, Iowa Podiatry Society, Iowa Society of Osteopathic Physicians and Surgeons, and Iowa Veterinary Medical Association.

In October, the Council sponsored its second Leadership Conference for officials of the member groups, and over 100 persons attended. Highlights of the program included a presentation on the cult of chiropractic by H. Thomas Ballantine, M.D., Chairman of the AMA Committee on Quackery, and a luncheon address by Lt. Governor Arthur Neu. The text of Doctor Ballantine's presentation was published in the January 1974 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

The annual IHC dinner for members of the Iowa General Assembly and other state officials was held February 5. This is mainly a get-acquainted social function, with no formal program, except for a brief presentation by the organization's president on the general purpose and activities of the Council. Emphasis is placed on the fact that the Council represents approximately 14,000 individuals involved in health care.

IMS staff and office facilities are utilized to coordinate and implement the various projects and programs of the IHC.

C. E. RADCLIFFE, M.D., Chairman

#### COMMITTEE ON SCIENTIFIC WORK

The 1974 annual scientific session will be held in Iowa City, Iowa, April 18, 19 and 20. Every effort has been made by the Program Committee to assure physicians an outstanding continuing medical education experience, and guarantee a diversion from the routine lecture/student approach.

The complete program will appear in the March issue of the JOURNAL OF THE IMS, and supplemental information will be sent directly to all Society members.

R. H. FLOCKS, M.D., Chairman

#### COMMITTEE ON STATE DEPARTMENTS

As has been noted regularly in this brief report, the Committee on State Departments is provided for in the by-laws to assure that the Society has an organizational mechanism to deal with various major aspects of public health. The six subcommittees which exist under the umbrella of the Committee on State Departments perform a valuable service on behalf of the medical profession. The subcommittees are Aging and Chronic Illness, Maternal and Child Health, Psychiatric Care, Public Assistance, Rehabilitation and Safe Transportation.

The chairmen of these several Subcommittees comprise the Committee on State Departments. And it is the purpose of the Committee on State Departments to function in a broad liaison fashion with the State Department of Health. Acknowledgement is made of the three physicians who serve on the State Board of Health: E. E. Gamet, M.D., Lamoni, who is the chairman; P. J. Leehey, M.D., Independence, and P. M. Seebohm, M.D., Iowa City. In the past year, Norman L. Pawlewski has been named to succeed Arnold M. Reeve, M.D., as Commissioner of Public Health. Mr. Pawlewski, who has been associated with the Department for approximately eight years, is the first non-physician to serve as Commissioner.

Information on public health matters is published regularly in the Journal of the Iowa medical society and in other IMS publications.

Members of the House of Delegates are encouraged to read the separate reports of the Subcommittees which follow. Various Iowa health care programs are described in this material.

A. H. Downing, M.D., Chairman

# SUBCOMMITTEE ON AGING AND CHRONIC ILLNESS

In its 1973 report to the House of Delegates, the Sub-committee on Aging and Chronic Illness presented information on the addition of intermediate nursing care provisions to the Medical Assistance (Title XIX) program. The Subcommittee reported the 1973 implementation of this program to the IMS Executive Council. The Council in turn approved support of the State Department of Social Services (SDSS) in its required administration of the program.

An update on this Intermediate Care Facilities Program (ICFP) was submitted to Iowa physicians in a summary article in the November, 1973 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

The State Department of Health has seven residential classifications in the custodial and nursing home field. Two of these seven—basic nursing homes and intermediate nursing homes—are included in the ICFP. The basic difference in these two categories is found in the kind and amount of nursing service provided.

Now entering its second year, the ICFP has several aspects which involve physicians. For instance, the state agency (SDSS) administering the Medicaid program must determine there is a "medical necessity" for each individual admission to an intermediate care facility. It must also assure that a "written plan of services" has been developed. These steps must be completed before the state is permitted to authorize payment.

The SDSS has developed a medical form (MA-2130-0) to be completed for each public assistance recipient entering a nursing home. This form is initiated by the county offices of the SDSS and sent to the recipient's physician. The physician is asked to list the diagnosis and plan for treatment, to indicate whether basic or intermediate nursing home care is required, and to estimate the length of time care will be needed. The physician forwards the form to the nursing home. The nursing home adds its nursing care plan and sends the form to the SDSS. The Department is then in a position to authorize payment for care in the nursing home.

Periodic re-evaluations of an individual's need for nursing home care are required. High costs have made this necessary. In fiscal year 1974, Iowa will spend over \$33 million of its \$67 million Medicaid budget on nursing home care. Physicians must recertify at least every 60 days that an individual requires nursing home care.

The SDSS has acknowledged this recertification places a burden on physicians with over 10,000 Title XIX par-

ticipants in the ICFP. Several alternatives have been devised to facilitate the recertification.

In addition, "independent professional reviews" must be conducted by the SDSS four times a year. The participation of attending physicians in these reviews is optional.

In one further activity of the Subcommittee, we are able to report that the Society was represented at a June seminar in Kansas City sponsored by the American Medical Association and devoted to "The Problems of Providing Organized Medical Care in Long Term Care Facilities."

E. E. LINDER, M.D., Chairman

# SUBCOMMITTEE ON MATERNAL & CHILD HEALTH

The Subcommittee on Maternal and Child Health has met on two occasions this year. Attention has been given in these meetings to these principal items:

1. Termination of Pregnancy. The Subcommittee reviewed its recommended policy statement which was approved by the 1973 House of Delegates. The statement offers guideline direction in any termination of pregnancy activity. The guidelines entrust responsibility for implementing a reporting program to the State Department of Health. In this connection, the Subcommittee reviewed reporting forms used in several states and has counseled with SDH officials on this matter. The Subcommittee (1) acknowledges the importance of this type of reporting, and (2) expresses reservation as to the reporting level which may be achieved. The Subcommittee believes member physicians should be urged to comply.

2. Immunization. This subject is of continuing high interest to the Subcommittee. In 1973 Society endorsement was given to the "Rapid Response to Measles Program" offered by the Iowa State Department of Health. In this action the Society encouraged county medical societies to use the program to minimize rubeola morbidity. Additionally, the Subcommittee examined the action of the 1973 House to "encourage and support immunization for all children on a voluntary basis"; this language was modified to substitute the word "voluntary" for "compulsory." The State Department of Health has volunteered to provide further information on immunization legislation as it becomes available. Other activities of the SDH in the immunization area have been shared with the Subcommittee, e.g., use of an incoming WATS line for reporting by physicians and others; the decline in administration of polio vaccine; the excellent efforts of Iowa physicians, school nurses, etc., in the measles eradication efforts. The Subcommittee assisted in the October, 1973 observance of Immunization Action Month.

3. Maternal Mortality Committee. This long-standing committee has been inoperative since the retirement of Dr. Madelene Donnelly-Healy. The Subcommittee has instituted efforts to revitalize this educational program with assistance to be provided by William Keettel, M.D., at the College of Medicine. In addition to evaluating maternal deaths, the Subcommittee has also discussed the merits of a committee to study perinatal and neonatal mortality.

4. Early & Periodic Screening, Diagnosis and Treatment of Children. This Medicaid program was broadened last July to include ADC recipients between 7 and 21. The administrative and reporting aspects of this program were noted with apprehension.

5. Family Planning. The requirement that pap smears and other lab work be sent to California for analysis under this federally funded program has been taken up with SDH officials. A resolution protesting this approach was considered by the 1973 House of Delegates. The SDH rep-

resentatives defend the requirement from the economic standpoint; they also claim the laboratory is reputable. The House has urged physicians to employ the "usual and customary fee" principle and to specify laboratories of their choice.

6. Statewide Perinatal Care Program. This new activity has been brought to the attention of the Subcommittee. A principal aspect of the work has been that of providing consultation to small Iowa hospitals on techniques in the care of mothers and infants.

Other matters have been given consideration by the Subcommittee, e.g., continued support of the Iowa Youth-power Project, the Parents Anonymous program for child abusers, legal ramifications of adoption involvement, mongoloid risks in over-40 pregnant women, and neonatal ophthalmia.

In the event specific recommendations are formulated by the Subcommittee prior to the 1974 Annual Meeting, they will be presented in the form of a supplemental report.

GEORGE L. BAKER, M.D., Chairman

#### SUBCOMMITTEE ON PSYCHIATRIC CARE

The Subcommittee on Psychiatric Care has met five times in the 1973-74 Society year and has an additional meeting scheduled for April 3. In these meetings the Subcommittee has considered numerous matters which relate to the delivery of care for nervous and mental diseases. Following is a highlighting of the principal considerations of the Subcommittee:

- Met with officials of the Clarinda, Mt. Pleasant, Independence and Cherokee Mental Health Institutes and the Iowa Security Hospital (Oakdale) to receive information on the programs available at these state facilities. Methods of treatment, costs, personnel, referral practices, and medications were among the topics discussed. Based on available information, the Subcommittee is not in support of closing any of the MHI's.
- Continued evaluation of the state's commitment statutes independently and through the joint committee which includes three physicians and three attorneys from the Iowa State Bar Association. Presently in draft form is a bill to revise totally the statutes covering the hospitalization of the mentally ill. The measure is being adapted by the Mental Health and Juvenile Institutions Study Committee of the Iowa General Assembly from materials developed by the joint IMS-ISBA committee. Total overhaul of the statutes is considered worthy of serious consideration inasmuch as the current commitment laws stand a chance of being declared unconstitutional. The Subcommittee has acknowledged that consideration of the broad bill may jeopardize a more limited proposal dealing with emergency commitment. This latter measure has been advocated by the Subcommittee for several years and has been ruled constitutional by the Attorney General. In this connection the Subcommittee has followed closely a threatened suit in Polk County where an involuntary confinement action involving the County Hospitalization Commission is questioned. The Subcommittee has recommended IMS legal support be provided in this case should it come to court.
- Studied several additional legislative proposals, e.g., a bill to provide a more explicit framework for the establishment and operation of community mental health centers; reaffirmed opposition to legislation to license psychologists and with this, licensure of social workers.
- Met on two occasions with representatives of Blue Cross/Blue Shield in a stepped up effort to clarify, update and improve aspects of mental health benefits afford-

ed or administered by BC/BS. Questions have been raised in the discussions regarding claims handling errors, inconsistencies in claims payments, coverage of psychologists and social workers, etc. Reference materials (a diagnostic guide of the American Psychiatric Association and a survey summary of Iowa psychiatric fees) have been provided to BC/BS by the Subcommittee. A summary of psychiatric benefits has been prepared by BC/BS for the Subcommittee. Efforts are now being made to update nomenclature and to clarify certain benefit provisions. It is hoped that out of this will evolve an understandable and acceptable summary of coverages which can be distributed to Iowa psychiatrists and other interested physicians. The Subcommittee and the Executive Committee of the Iowa Psychiatric Society have indicated their desire to cooperate fully with BC/BS and the Iowa Foundation for Medical Care in this effort to structure improved delivery procedures for acute psychiatric care.

- Approved a patients' rights platform in the nature of ethical principles or guidelines for reference use but not as statutory requirements.
- Supported the Society serving as a cooperating agency for the Symposium on "Contemporary Medicine and Social Change" presented by Geigy Pharmaceuticals on November 7, 1973.

Various other subjects have been discussed by the Subcommittee in the course of its deliberations. The preceding are regarded as the most salient and will afford the House of Delegates some understanding of the matters being pursued by the Subcommittee.

HERBERT L. NELSON, M.D., Chairman

#### SUBCOMMITTEE ON PUBLIC ASSISTANCE

The Iowa Medical Society remains in contact with the State Department of Social Services on the Iowa Medical Assistance Program (Title XIX/Medicaid). The effective work of Elmer M. Smith, M.D., Director, Bureau of Medical Services, SDSS, and his associates, in coordinating the Medicaid Program deserves to be acknowledged.

In 1973 Iowa Medicaid disbursed \$52.7 million with 59.7% of this coming from federal sources and 40.3% from state funds. Of this sum, \$5.5 million (10.4%) was paid to medical doctors; osteopathic physicians received just over \$1 million (1.9%). Other principal providers received reimbursement on the following percentage basis: inpatient hospital—16.2%; pharmacies—10.2%; intermediate care facilities—50.9%; and dentistry—4.5%.

The number of Medicaid recipients who received services from MD's in December 1973 totalled 17,030 with the cost per recipient averaging \$25.88. MD services in December included 37,192 office visits, 381 home visits, 9,133 hospital in-patient visits, 1,623 hospital out-patient visits, 95 clinic visits, 2,490 nursing home visits, and 2,434 dispensed prescriptions.

The most significant recent development in Medicaid is the new federal program of Supplemental Security Income for the aged, blind and disabled which began January 1, 1974. This program, which is federally financed and administered by the Social Security Administration, replaces the state public assistance programs of old age assistance, aid to the blind and aid to the disabled. The new program establishes a uniform nationwide set of eligibility criteria and a standard nationwide basic payment. The basic payment under the new program for a person living in his own home is \$140 per month for a single individual after \$20 of income from any source is disregarded. For a couple living together the payment will be \$210 per month after the income disregard. Application for the new program is made at the SSA District Office serving

the county in which the person resides. For persons who are determined eligible for SSI, payments will be made on a monthly basis directly from the SSA.

The federal government offered states administering Title XIX programs several options in covering SSI beneficiaries. In Iowa, the Department of Social Services elected the most liberal option, namely, to extend Title XIX coverage to all beneficiaries of the new program. Approximately 16,000 former recipients of OAA, AB and AD in Iowa have been "converted" to the new program. By the end of 1974 it is anticipated the total SSI case load in Iowa will rise to at least 40,000.

All beneficiaries of SSI have a white Medical Assistance Identification Card issued by the SDSS. This is the only card this group of recipients has. The monthly eligibility card (colored card) will not be used in connection with SSI beneficiaries, although its use will be continued in ADC cases. As in the past, if the Medical Assistance Identification Card indicates the recipient has health insurance, it will be necessary for the physician's office to contact the County Department of Social Services for an authorization. Other than the change in the ID card system there have been no other significant revisions in program procedure to affect physicians.

The Subcommittee on Public Assistance has met once this year with SDSS officials as the State Physicians Advisory Committee to Title XIX. The principal item of discussion at this meeting was the physician signature requirement on Title XIX prescriptions. The Society continues to be represented by the chairman of the Title XIX-Medical Assistance Council.

A. J. HAVLIK, M.D., Chairman

#### SUBCOMMITTEE ON REHABILITATION

The Subcommittee on Rehabilitation has not had occasion to meet this year. Reference should be made however to the amendments in the Social Security Act which have altered the nation's Social Insurance and Public Assistance programs. The new Supplemental Security Income program replaces the past federal-state programs of public assistance payments to the people who are aged, disabled and blind.

The new program will allow a nationwide base of income for those disabled and blind who meet the eligibility requirements. Responsibility for administration of the program has been assigned to the Social Security Administration.

The State Disability Determination Division will be involved in the qualification of applicants who are blind or disabled and who are under 65 years of age. The medical community has been requested to assist as necessary in providing supportive medical evidence for those who apply for benefits from this category.

Several explanations of the preceding revisions have been presented in the Journal of the Iowa medical society.

In addition, the December issue of the JOURNAL presented an article by Homer E. Wichern, M.D., Des Moines, in which he noted levels of disability by disease and compared Iowa with the rest of the nation. Dr. Wichern is chief medical consultant, Rehabilitation Education and Services Branch, Iowa Disability Determination Unit, Social Security Disability Program.

C. B. LARSON, M.D., Chairman

#### SUBCOMMITTEE ON SAFE TRANSPORTATION

Early last summer, the Committee on Safe Transportation hosted a one-day conference involving the Commissioner of Public Safety and his assistants, the head of the Iowa State Highway Patrol and several officers of the Patrol, officials of the Bureau of Criminal Investigation and the State Department of Health, and representatives of the IMS Committee on Emergency Medical Services.

The meeting was arranged to discuss informally various matters of mutual interest and concern, and to exchange ideas with respect to reducing the number of automobile injuries and fatalities. Specific attention was given to legislative proposals relating to ambulance standards and services, and implementation of the implied consent law.

The Commissioner of Public Safety acknowledged the excellent liaison and cooperation which exists between officials of the IMS, DPS, and Highway Patrol, and there was unanimous agreement that the conference served a valuable educational purpose. It is anticipated that similar joint meetings will be held in the future.

The Medical Advisory Board to the DPS continues to review and make recommendations on medical reports required by the DPS on certain drivers license applicants. There is mutual agreement that the anonymity of the Board will be maintained in order to assure its continued effectiveness and service.

A. H. DOWNING, M.D., Chairman

#### PUBLICATIONS COMMITTEE

While the JOURNAL OF THE IOWA MEDICAL SOCIETY has diminished in size in recent years, we hope the material selected for publication (both scientific and socioeconomic) is of interest and value to member physicians. We have continued this past year to present material we believe to be topical, interesting, succinct, accurate and readable.

New ideas are being implemented within budgetary bounds in an ongoing attempt to be innovative. For example, the "Question Box" feature has been appearing the past year or so. This regular question-and-answer exchange attempts to focus briefly on a timely issue by presenting the opinions of an involved person.

The support of various individuals in developing material for the Journal is much appreciated. Editorial thoughts of several Society officers have been received and published this year. We continue to be grateful to Richard M. Caplan, M.D., for his efforts in behalf of the Journal at the University of Iowa College of Medicine. Manuscripts from the academic community form the backbone of our scientific section. Of course, we are pleased to have papers from those Iowa physicians who are busy in private practices. We are pleased to note an upswing in the number of manuscripts from this sector.

As is our custom in concluding this brief report, we would like to renew our pledge to provide Iowa physicians a journal which aims to help them stay informed on important subjects of the day, particularly those which have a bearing on the State of Iowa. We invite you to submit your suggestions, case reports, scientific manuscripts and news items to the JOURNAL.

MARION E. ALBERTS, M.D., Scientific Editor

# Reports of Special Committees COMMITTEE ON ALCOHOLISM

The Committee on Alcoholism has had a busy year and is pleased to summarize its activities in this report. Five meetings have been held in the 1973-74 Society year. On January 24, 1974, the chairman presented a report to the IMS Executive Council. This report, which was approved by the Council, included three principal items:

1) A recommendation from the Committee that the So-

ciety support a proposed pilot treatment project which emphasizes concentrated outpatient alcohol counseling. Still in the development stage, the project will involve Blue Cross/Blue Shield, Northeast Iowa Council on Alcholism and Schoitz Hospital in Waterloo. The program will encourage brief hospitalization for detoxification to be followed by intensive follow-up attention provided by certified alcohol counselors. It is anticipated a contractual arrangement between Schoitz and BC/BS will be developed to support the program's providers of service. It is hoped the program will (1) produce a good recovery rate, and (2) hold treatment costs down. The Committee has met with BC/BS officials to discuss the program, and the chairman has visited facilities in Waterloo to receive an on-site briefing. The Committee expects to follow the pilot project as it progresses and will evaluate its results before recommending any expansion.

2) A suggested management protocol for use by physicians in treating alcoholic patients. The protocol covers acute alcohol intoxication, acute withdrawal, sedation, seizures, fluids and diet, vitamins, analgesics and antacids, coma, follow-up therapy, long term treatment, counseling, Alcoholics Anonymous, psychiatry, religion, drugs, and success of therapy. The guidelines will be published in the JOURNAL OF THE IOWA MEDICAL SOCIETY in the near future and will be provided to the Iowa Foundation for Medical Care for its reference use.

3) A recommendation that the Society follow closely and very likely support a legislative proposal to "decriminalize" alcoholism, i.e., to offer medical treatment to individuals apprehended for intoxication. The Committee has met with two state legislators, Senators Minette Doderer and Tom Riley, and other knowledgeable individuals, to review the concepts embodied in the proposed legislation. The Committee has approved in principle the intent of the legislation and expects to follow its developments during the current session of the Iowa General Assembly.

In other activities during the year, the Committee (1) continued its efforts to stimulate youth participation in educational programs (a mailing has been sent to county societies encouraging them to sponsor a local student at the 1974 Buena Vista summer workshop); in addition, the Committee met October 17 with student participants in the 1973 summer program; (2) assisted in the presentation of an educational program for the Linn County Medical Society; (3) attempted to stay abreast of developments of the Iowa Commission on Alcoholism and the Iowa Alcoholism Project of the Office of Planning and Programming; (4) maintained liaison with the State Department of Public Instruction in an effort to be supportive of its efforts in the educational area; (5) recommended the Society serve as a co-sponsor of the 1974 Northwest Iowa School on Chemical Substances and Other Addictions: (6) counseled with representatives of the Polk County Board of Supervisors regarding treatment practices for alcoholic patients; and (7) visited the Cherokee Mental Health Institute and received a briefing on the Institute's treatment program for alcoholics.

The involvement of the Committee in these various programs and projects has been gratifying. Interested and loyal committee members have made it possible.

S. M. HAUGLAND, M.D., Chairman

#### COMMITTEE ON ARCHITECTURAL EDUCATION

The Committee on Architectural Education has nearly completed a set of guidelines and procedures, prepared as a flow-chart, for use by those involved in hospital/health facility building programs. This project, developed with

representatives of the Iowa Chapter/American Institute of Architects, was undertaken to assure that a hospital or health facility structure will meet effectively the needs of those who provide health care, and the recipients of that care.

The guidelines emphasize that (1) there be a broad base of physician participation in the initial planning of a building; (2) the architect who designs the facility should have early access to and consultation with the physicians who will utilize it; and (3) there should be continuing contact between the physicians, the architect, and the facility administrator.

Last August, Committee representatives met with officials of the Iowa Hospital Association to review the proposed document, and to seek IHA cooperation in its printing and distribution after final approval by the IMS, Iowa Chapter/AIA, and IHA. The IHA is now preparing an additional statement to be included in the guidelines, which will refer to requirements for obtaining approval of appropriate state (Office for Comprehensive Health Planning) and areawide planning agencies for proposed capital expenditures by or for health care facilities, as stipulated under P.L. 92-603.

The Committee anticipates the guidelines will be completed in the near future, so that a final draft can be submitted to the IMS Executive Council for approval, and then made available to the memberships of the IMS, Iowa Chapter/AIA, and IHA.

J. E. Kelsey, M.D., Chairman

#### COMMITTEE ON BLOOD BANKING

In response to a 1972 directive from the President, and a confrontation on blood policy forced by HEW, a national blood policy was prepared under duress and presented to the government on January 31, as requested.

This policy calls for the formation of an American Blood Commission. The organizations involved include the American Association of Blood Banks, The American National Red Cross, and the Council of Community Blood Centers.

The threat of a federally mandated national blood program is, at least, momentarily delayed. There are many non-physician groups ready to take over blood banking. It is essential that physicians maintain an active role so that the key requirement—"patient welfare"—is the major premise of the program.

Your Committee will begin a study of applications for this program in Iowa as soon as the plan is published. You will be kept informed.

W. S. PHETEPLACE, M.D., Chairman

# COMMITTEE ON COMMUNITY EMERGENCY MEDICAL SERVICES

The Committee on Community Emergency Medical Services considered and made recommendations on two important items that were subsequently acted upon by the House of Delegates when it met in regular session October 12-14, 1973. The items concerned a program of the Governor's Advisory Council on Emergency Medical Services to categorize emergency medical services of the state, and a request from the Iowa Heart Association and the State Department of Health for IMS support and assistance in developing legislation which would permit a Certified Mobile Intensive Care Paramedic to perform certain lifesaving procedures for which he is specifically trained.

In response to recommendations of the Committee, the House directed that (1) in view of the uncertainty re-

garding the proposed EMS categorization classifications, more study be given by the Society and by the Governor's Advisory Council to the categorizations and category criteria, with the goal in mind of making them more compatible to Iowa; (2) that the IMS support the general concept of authorizing formally trained and certified mobile intensive care personnel to perform certain lifesaving procedures under specified conditions set forth by the medical organization responsible for the ultimate care of the persons involved; further, that the IMS Committee on Legislation consider the merits of supporting enabling legislation, including appropriate liability provisions, as well as a provision for the State Department of Health to establish standards and rules, with advice and counsel from an advisory council which would include IMS representation; and finally, if IMS support of such legislation is deemed desirable, the Legislative Committee should consult with the Heart Association and the Health Department in developing an appropriate bill.

The recommendations of the House regarding categorization of emergency medical facilities have been reported to the Governor's Advisory Council on EMS, of which the Committee chairman is a member. Progress is being made in completing this project. In addition, House action on the proposed MICP legislation has been directed to the IMS Legislative Committee, and it will study the matter.

The State Advisory Council on EMS will sponsor a second Statewide Conference on Emergency Medical Services in Des Moines in March. Details will be provided to the membership.

A. H. Downing, M.D., Chairman

#### COMMITTEE ON DELEGATION OF AUTHORITY

The Committee on Delegation of Authority has not met this year. The House will recall this committee was appointed in June, 1972 to confer with nursing representatives on questions relating to the delegation of authority by physicians to nurses and others, as well as other matters of mutual interest and concern.

The Committee also has official status as the Joint MD/Nurse Liaison Committee, serving with representatives of the Iowa Nurses' Association and the Iowa State Board of Nursing. The Committee stands ready to meet with these nursing groups, so that relations and communications between the two professions can be enhanced and an appropriate forum for discussion of issues and mutual problems can be maintained.

In past sessions with nursing representatives, specific attention has been given to the question of delegation of authority, proposals and programs relating to expanding the role of the nurse in health care, and the role of the physician's assistant. A joint statement on the subject of "ear piercing performed in nonmedical settings" was developed and approved last year by the Executive Council.

The Committee chairman served this year as the Society's representative on the Governor's Commission to Study Nursing in Iowa. The Commission is in the process of identifying and analyzing many of the vexing problems confronting nursing, e.g., nursing practice, nursing education and continuing education.

The Iowa Nurses' Association has been working for some time on a revised version of a proposed statement on "Standards of Nursing Practice in Hemodialysis Units." The Committee will review this document when it is resubmitted for consideration and action by the IMS. In previous years the IMS, INA, and the Iowa Hospital Association have approved joint statements on "The Intravenous Administration of Fluids and Medications by

Professional Nurses Practicing in Hospitals or Organized Agencies in Iowa," and "Nursing Functions for Registered Nurses Practicing in Hospitals or Organized Agencies in Iowa."

L. F. STAPLES, M.D., Chairman

### COMMITTEE ON DELIVERY OF HEALTH SERVICES

The Committee on Delivery of Health Services has responsibility for maintaining liaison with, and providing pertinent advice to, the Iowa State Office for Comprehensive Health Planning as it develops criteria and formulae necessary to define the health needs and programs of Iowa, in accordance with guidelines prescribed in P.L. 92-603. Under P.L. 92-603, OCHP is designated as the authority to review, with specific cost-limiting intent, proposed capital expenditures by or for health care facilities and HMOs.

The Committee has given considerable attention to a proposed Comprehensive Health Plan for the State of Iowa, a project of OCHP. The Plan was developed by OCHP staff and incorporates ideas emanating from the OCHP Advisory Committee, its committees and task forces. The principal stated purpose of the Plan is to "provide guidelines for the orderly provision of definitive and preventive health care to all citizens of the state, including the development of needed resources." Primary emphasis is on (1) Planning principles (concerns for patients, quality of care, cost efficiency, role of consumer, preventive health); (2) Regional Planning Guidelines (specific role of areawide planning councils in drafting area health plans related to the State Plan); (3) Minimum Criteria Plans (information from statewide health agencies and organizations, and other experts, to establish reasonable state coverage of categorical services).

The Plan also includes (a) reference to a "stratified" health system and a description of "levels of care"—i.e., primary, secondary, tertiary; (b) details regarding the structure of OCHP and its responsibilities under P.L. 89-749, and P.L. 92-603; and (c) "review and comment" guidelines for areawide health planning agencies.

A statement developed by the Committee in response to the proposed OCHP Comprehensive Health Plan for the State of Iowa was approved by the Executive Council at a meeting January 24, 1974. This statement has been submitted to OCHP for its information. The statement reads as follows:

"The Iowa Medical Society views the 'Comprehensive Health Plan for the State of Iowa,' prepared by the Advisory Council/Office of Comprehensive Health Planning, as an excellent summary of OCHP responsibility under P.L. 89-749 and P.L. 92-603, as well as a clear source of information pertaining to applications for health facilities approval required by law. Many general planning principles and broad statements of health care philosophy are appropriately included as guideline commentary.

"As a comprehensive health plan for Iowa, however, the document does not provide specific goals or suggestions. This is perhaps appropriate during a period of painful societal changes at many points in the 'health care system.'

"The IMS agrees that the efforts of local planning groups should be responsive and responsible to area needs. Such groups should be supported in their efforts to reach conclusions about projects and policies affecting medical services in a given region. Too rigid application of bureaucratic review would tend to restrict efforts to compromise and settle issues existing at local levels.

"The IMS will respond directly to requests for review and comment on this Plan, or other similar documents, and will continue to follow with interest and concern the development of a valid 'Comprehensive Health Plan' for the state. The Society is alert to changes implicit in P.L. 92-603, as well as proposed legislation for national health insurance, HMO's, PSRO's, etc.

"The IMS wishes to cooperate with all groups and agencies seeking orderly evaluation and study of a 'changing system of health care delivery.' Only by truthful interchange and direct participation can the planning processes be utilized effectively in resolving the issues being considered by all concerned citizens of our nation in this time of profound change.

"The IMS urges that participants in the health planning process be well informed on health matters. It also emphasizes that it is important and essential for the physician to maintain a prime role in determining policies which would be applicable in the delivery of health care.

"Now, in direct response to a request from OCHP, the IMS is pleased to offer the following comments:

"I. In considering health care priorities for the State of Iowa, the IMS feels attention should be focused on the following:

"A. Manpower—Medical and Paramedical: Recruitment and retention, utilization of existing personnel, distribution of personnel.

"B. Improved Emergency Medical Services and Facilities: Transportation and communication, training and utilization of Emergency Medical Technicians (EMT).

"C. Since the various regions in the state have resources, needs and problems that may be unique, local involvement and decision-making in all aspects of health planning should be strengthened and supported.

"D. Further review, evaluation, coordination of activities, and support of programs such as Home Health Care, Visiting Nurses (County Public Health Nurses), Day Care Centers, Social Services.

"E. Assure quality medical services to state institutions—e.g., prisons, custodial homes.

"In listing health care priorities, it seems appropriate to note some of the ongoing activities and efforts to resolve many of our problems, for instance:

"• The creation of family practice residencies in various community hospitals in the state. It is well substantiated that a physician usually locates in the area where he/she completes an internship or residency. There are now 47 physicians in training to become family physicians; in 1971, only six physicians were engaged in family practice programs. By 1976, there could be as many as 156 family practice residents in training, with a completion potential of 52 per year.

"• Enactment of Physician's Assistant legislation in Iowa, and the initiation of a PA training program at the University of Iowa College of Medicine.

"• The development of 'model' health care delivery programs by the U of I College of Medicine—e.g., the Family Practice Rural Health Center at Oakdale and the Community Health Center at Muscatine.

"• The creation of the Iowa Foundation for Medical Care, which is a functioning peer review organization, with the objective of assuring quality medical care for the people of Iowa, and fair and equitable cost reimbursement to the providers.

"• The tailoring and scheduling of continuing education programs designed to meet the needs and desires of physicians and paramedical personnel, and to further enhance quality of care.

"• The appointment of the Governor's Advisory Coun-

cil on Emergency Medical Services, and its work in evaluating and categorizing emergency facilities.

"• Local and areawide health planning activities received a head start in Iowa as a result of the voluntary efforts of a group of providers and consumers who formed the Health Planning Council of Iowa.

"II. In reference to the definition of the terms 'primary,' 'secondary,' and 'tertiary' care, the IMS is of the opinion that:

"a. The terms as outlined in the proposed Plan are acceptable. In 'The Report of the Citizens Commission on Graduate Medical Education' commissioned by the American Medical Association in 1966, there is an excellent discussion of the present concepts and definitions relating to the primary care physician, his role and scope of services within a changing system of health care delivery.

"b. The stated definitions of primary, secondary, and tertiary should be recognized as guidelines, and no rigid lines should be established between these levels of care."

John Tyrrell, M.D., Manchester, was appointed by Governor Ray in the Fall to serve on the OCHP Advisory Group. Dr. Tyrrell has agreed additionally to serve as the Society's liaison with OCHP.

A year ago, the Executive Council approved a Committee recommendation that the IMS co-sponsor a series of regional meetings to consider long-range health plans for various areas in the state, utilizing as a basis for discussion a document entitled "A Proposed Organizational Structure for Providing Health Services and Medical Care in the State of Iowa." The document was prepared by John MacQueen, M.D., University of Iowa College of Medicine, and Eber Eldridge, Ph.D., Professor of Economics, Iowa State University, and it has been approved as a concept by the Health Manpower Committee of the OCHP Advisory Groups. It contains suggested organizational units through which health services could be provided, as well as demographic data and information about physicians in 16 designated regions in the state.

Last Spring, IMS representatives met with officials of OCHP and the U of I College of Medicine to begin initial planning for the proposed series of regional meetings. At that time, it was reported OCHP would request each official areawide health planning agency in the state to survey the medical services and resources available in the area, and to develop recommendations with respect to what could and should be done in the area to enhance accessibility to and availability of medical care. Recently, the Committee was advised that the survey results would not be available before the Spring of 1974; hence, further planning for the regional meetings has been delayed.

At its 1973 Annual Meeting, the House of Delegates referred to the Committee a resolution from the Dallas-Guthrie County Medical Society on the subject of rural medical family practice units. The Committee plans to meet with representatives of the county society and other appropriate individuals, and specific recommendations regarding the resolution will be submitted to the House in April.

M. E. Olsen, M.D., Chairman

#### COMMITTEE ON DRUG ABUSE

The Committee on Drug Abuse has continued to maintain liaison with the Iowa State Drug Abuse Authority, which was established by the 65th Iowa General Assembly. The IDAA has been assigned responsibility for planning and coordinating state drug abuse programs.

The IMS has nominated F. W. Bennett, M.D., Committee chairman, to serve on a State Advisory Council on

Drug Abuse as a non-voting member, in accordance with the new law.

Mr. Fred Brinkley, IDAA Director, met with the Committee in November, 1973 to review a Comprehensive State Plan for Drug Abuse Prevention, and to discuss related matters.

The Committee has given special attention in its meetings to problems related to prescription drug abuse and drug-alcohol interaction. In this connection, Mr. Brinkley has advised the Committee abuse of prescription drugs is of such significance that a special attack on the problem is warranted; further, if this is not done, it is possible that controls will be established via federal rules and regulations.

At a January meeting, the Committee considered its role vis-à-vis drug abuse problems, and there was concurrence on the following points:

1. The IMS, and physicians, should concern themselves primarily with medical problems related to illicit drug abuse. In this regard, it was acknowledged that, by statute, the responsibility for planning and coordinating drug abuse and preventive functions has been assigned to the Iowa State Drug Abuse Authority.

a. Where appropriate, however, the IMS and physicians must participate in an advisory capacity in the various programs designed to thwart drug abuse and to "rehabilitate" the drug abuser.

b. The physician should provide direction and guidance to agencies and individuals involved in drug abuse prevention counseling programs.

2. The major function of the Committee in the coming months should be to explore problems related to licit drug abuse and misuse. As a part of the Committee's continuing study and concern in this regard, attention should be given to the drug prescribing practices of physicians.

The Committee will meet again in March to discuss the development and implementation of an education program for physicians (item #2 above). Specific recommendations will be presented to the House of Delegates in a supplemental report in May.

A member of the Committee, Kirk Strong, M.D., has co-authored a paper titled "Methaqualone: An Irrational Hypnotic" for publication in a future issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY. As announced by the Committee in a December 12 News Bulletin to the membership, Methaqualone is now a Schedule II drug under FDA regulations, and physicians were and are urged to use an alternative medication when a sedative is indicated.

F. W. BENNETT, M.D., Chairman

#### COMMITTEE ON EYE CARE

The Committee on Eye Care considers questions relating to relationships between ophthalmologists and opticians and others. In addition, the Committee reviews matters relating to hearing, and in that capacity has consulted with the Department of Social Services (Title XIX) on its program of payment for hearing aids. The Committee has functioned in this regard primarily as a consultant to determine the appropriate role of 1) the otologist, 2) the audiologist, and 3) the hearing aid dealer.

On matters relating to eye care, the Committee has consulted with representatives of Blue Cross/Blue Shield to evaluate the feasibility of establishing an "eye care program." The Committee is continuing discussions with Blue Cross/Blue Shield officials and if there are recommendations which need to be considered by the House of Delegates, they will be submitted in a supplemental report.

A. H. Downing, M.D., Chairman

#### COMMITTEE ON GROUP INSURANCE

The Committee on Group Insurance is pleased to advise of a new health care coverage which is now available to interested Society members. The Committee has worked with Blue Cross/Blue Shield representatives in 1973 to develop this additional group health program which has broad benefits. The new program is offered in addition to the existing coverage (which has been modified only slightly, principally (1) to provide UCR payments, and (2) to reduce nervous and mental benefits).

Information regarding the new coverage was circulated to all member physicians in a late November letter from Society President Rubin H. Flocks, M.D. Follow-up contact has been and is being made on physicians throughout the state by BC/BS representatives. Enrollment in the new program will be open throughout 1974.

While the opportunity to become familiar with the program has been brief, a January 24 report shows 72 groups have enrolled in the program with 411 individuals involved. A large number of these individuals have moved into the new program from other BC/BS coverages.

It is hoped additional members will consider the coverage during 1974. It is available to members, their families and their employees. Those who are now enrolled in the existing statewide physicians group may continue in it, or they may transfer into the new program. Basic features of the new program are as follows: BLUE CROSS—365-Day Comprehensive (80/20 Coinsurance \$250 Maximum), 365-Day Nervous & Mental, 365-Day Drug Addiction, TB & Alcoholism, Inpatient Diagnostic, and Physical Therapy Admissions; BLUE SHIELD—365-Day U.C.R., 365-Day Drug Addiction, TB & Alcoholism, Inpatient Diagnostic, and Ambulance—Air & Ground. In addition, there is a \$250,000 major medical provision.

The monthly premium will be \$17.78 for single person coverage and \$45.57 for family coverage. If the program is accepted by an office or clinic all permanent full-time employees must participate except those who are included in group programs held by spouses.

Any Society member interested in learning more about this coverage is invited to contact Society Headquarters or Blue Cross/Blue Shield.

During the past year several important changes have occurred in the insurance programs offered to Society members through The Prouty Company in Des Moines.

The rates for the Guaranteed Renewable—Accident and Sickness Disability Income Plan were reduced for members under age 40. An open enrollment was held for members under 40 in conjunction with this rate reduction. During this time uninsured members under 40 were offered a basic amount of disability insurance regardless of past medical history. The response was excellent and a number of previously uninsured, younger members entered the program.

The Disability Program was also made Guaranteed Renewable for those members insured under the old policy form. The underwriting company instituted this measure on a nationwide basis because of the incidence of severe losses at the older ages. This transfer to the Guaranteed Renewable Policy form places everybody insured on the same step-rate premium basis, members under 50 will pay lower premiums than previously and members over 50 will pay higher premiums.

Another important change in this program, for all members, will occur in 1974 in the form of an improved definition of total disability. The new definition will apply to the insured's regular occupation, i.e., gynecology, internal medicine, radiology, etc. The previous definition de-

fined disability as inability to engage in the practice of medicine. The new definition will be in effect for the first 10 years of disability for those members who are insured under the plan providing Lifetime Accident and Sickness Benefits to age 65, and will be in effect for the first seven years for those members who are insured under the plan providing Lifetime Accident and Seven Years Sickness Reposits

The Accidental Death and Dismemberment Program was improved by increasing the upper limits available from \$100,000 to \$150,000 for both the physician and his spouse.

There will be an open enrollment under the Life Insurance Program in 1974. During the open enrollment, any uninsured member, under age 60, will be entitled to \$10,000 of coverage without evidence of insurability, if certain minimum underwriting requirements are satisfied. This coverage is available in amounts from \$10,000 to \$50,000 and automatically includes double indemnity and waiver of premium.

It is anticipated the sponsored Office Overhead Expense Disability Plan will be made Guaranteed Renewable in 1974. The maximum amount available has been increased from \$1,000 to \$1,500 monthly.

The In-Hospital Indemnity Program did not meet the minimum underwriting standards required during the charter enrollment period and, therefore, the plan was not established.

In addition to the preceding coverages, The Prouty Company continues to offer Excess Major Medical Coverage, Life Insurance to Members of the Woman's Auxiliary to the IMS, and "Gal Friday" Income Protection for employees of Society members.

Proposals for an IMS-sponsored Professional Liability Insurance program have been requested by The Prouty Company from the Aetna, Travelers and Hartford companies. Information on these possibilities will be submitted to the Medico-Legal Committee early in 1974.

The Prouty Company participated recently in an IMS-sponsored conference for specialty group representatives. The Prouty representatives volunteered to present information on the group insurance coverages to the various specialty organizations at any time. A similar possibility exists for county medical societies. The expansions and changes in the several programs would suggest there may be wisdom in devoting a specialty or county society meeting to this subject. Both The Prouty Company and the Committee on Group Insurance will be happy to assist any group in arranging an insurance program.

R. S. GERARD, M.D., Chairman

# COMMITTEE ON HEALTH CARE IN CORRECTIONAL INSTITUTIONS

This special Committee was created by action of the 1973 Hcuse of Delegates as an outgrowth of a resolution submitted by the Dubuque County Medical Society. The assignment to the Committee is to "investigate the quality of medical care at the correctional institutions in the State of Iowa and make any appropriate recommendations to the House that might be indicated by its findings."

The organization of the Committee was delayed for several unavoidable reasons. The Committee is now well-structured and is in the process of fulfilling its assignment

At the first meeting a lengthy and fruitful discussion was held with Mr. Nolan Ellandson, director, Bureau of Corrections, State Department of Social Services. He offered his full cooperation to the Committee. The election was made to limit the study of medical services to the

four principal facilities located at Anamosa, Fort Madison, Oakdale and Rockwell City.

Reference materials have been obtained from the AMA and other sources for background use by the Committee. Questionnaires were developed by the Committee and distributed to those in charge at Iowa's four correctional facilities. These questionnaires have been completed and returned.

At this time visits are being made by members of the Committee to the four institutions. These site visits have been structured to include a discussion with the warden or his representative; a tour of the facility, particularly its medical care areas; and a visit with representative inmates.

Various factors have been discussed at length by the Committee, e.g., the matter of full-time physician coverage versus part-time, the problem of liability coverage, etc. The Committee expects to present a further report to the House of Delegates in May.

ELMER M. SMITH, M.D., Chairman

# COMMITTEE ON HEALTH MAINTENANCE ORGANIZATIONS

This is a new special committee of the Iowa Medical Society. With the enactment of state HMO enabling legislation and also the passage of federal legislation to provide funding for HMO's, IMS officers consider it imperative to have a committee to deal with the complex issues surrounding Health Maintenance Organizations.

The Committee has met once since its formation to discuss two major items. The first deals with the establishment of HMO rules and regulations in Iowa. A special Advisory Committee to the Department of Insurance and the Department of Health was established to aid in drafting the rules and regulations. Marvin Dubansky, M.D., is the IMS representative on this Committee. The Advisory Committee has completed its draft of the rules, and we commend Dr. Dubansky for his excellent and dedicated contribution.

The second purpose for the first meeting was to discuss with representatives of Blue Cross and Blue Shield a proposed organizational structure for HMO's in Iowa. The Committee made several suggestions for changes in the organizational structure and was pleased at the willingness of the Blues to discuss these ideas.

This Committee will seek to stay abreast of HMO developments in Iowa and will also serve as a resource for Iowa physicians who desire information on HMO's.

JAMES F. BISHOP, M.D., Chairman

# COMMITTEE ON HEALTH PLANNING PROGRAMS

The Committee on Health Planning Programs did not meet this year. However, the Society has continued its liaison with the Office of Comprehensive Health Planning and the Iowa Regional Medical Program.

Several members of the Iowa Medical Society have been actively involved in the various programs. John Tyrrell, M.D., was elected chairman of the Iowa Regional Advisory Group and Paul Seebohm, M.D., succeeds John Sunderbruch, M.D., as vice chairman of the IRAG. Other physicians serving on the IRAG include: official IMS representative Kenneth Lister, M.D., John McQueen, M.D., Terry Dynes, M.D., William Bliss, M.D., and Robert Martin, M.D. Donald Soll, M.D., Donald Trefz, M.D., and Drs. Tyrrell and McQueen also serve on the Advisory Council to the Office of Comprehensive Health Planning.

In the 1973 Handbook report, federal funding cutbacks were cited with the explanation that the Regional Medical Programs would be phased out by June 30, 1973. Since the last report, however, federal funds have been released and it now appears that the Iowa Regional Medical Program will be in operation for an indefinite period of time.

Recent amendments to the Social Security Act which concern refund review for construction of health care facilities have been implemented. The State Office for Comprehensive Health Planning has been designated by the Governor as the agency to administer this program. Serving as the physician representative on OCHP's Health Facility Construction Review Committee is Robert Pfaff, M.D., Dubuque.

OCHP has also undertaken a program to draft a State Comprehensive Health Plan and has enlisted the assistance of the IMS as well as the other health provider organizations. The Committee on Delivery of Health Services has been working closely with representatives of OCHP in providing information necessary for the plan.

HOMER L. SKINNER, M.D., Chairman

#### HISTORICAL COMMITTEE

The Historical Committee was saddened last spring over the death of one of its most able members, William M. Morrissey, M.D., of Davenport. Dr. Morrissey was a medical historian of significant stature, and it is fortunate for Iowa medicine that he was able to complete his excellent and comprehensive manuscript dealing with midwest medical problems, progress, and opinions—1856-1892.

The IMS assisted Dr. Morrissey in reproducing a limited supply of his historical document, and a copy will be made available to interested physicians and individuals on request.

The Committee will be happy to produce limited quantities (25-50) of similar historical papers prepared by IMS members for use both by the author and the Society.

The "I Remember When . . ." column appears periodically in the IMS JOURNAL. The column features short articles by Committee members and others which describe changes in scientific medicine and medical practice that have occurred over the years.

The Committee has completed its project of obtaining photographs of all IMS presidents dating back to 1950 (the Society's centennial year). These pictures, and those of other physicians who will serve as presidents in the future, will be placed in one of the meeting rooms at IMS Headquarters.

Otto N. Glesne, M.D., Chairman

#### COMMITTEE ON INDEPENDENT LABORATORIES

The Committee has conferred on one occasion during the 1973-74 Society year. Approval was given on January 15 to a recommendation that the Iowa Medical Society endorse a voluntary Proficiency Evaluation Program (PEP) offered by the College of American Pathologists.

This recommendation was submitted to IMS Executive Council January 24 by John W. Green, Jr., M.D., a member of the Committee. The Council responded favorably and requested the program be brought to the attention of the Society's membership.

The following notice has been included in several Society publications and further effort will be made to promote the program:

LABORATORY PROFICIENCY . . . Iowa physicians are urged to consider a proficiency evaluation program for the office laboratory offered by the College of Ameri-

can Pathologists. Endorsement of the program was given by the IMS Executive Council January 24 as recommended by the Committee on Independent Laboratories. A folder describing the program is available on request from IMS Headquarters.

The Committee is aware of several states (California, Maryland and Arizona) that by law are requiring physician participation in a state-operated or state-approved proficiency testing program. This activity at the federal and state governmental levels is regarded by the Committee as sufficient reason to endorse and promote the CAP PEP.

A letter of endorsement for the PEP program has been filed with the Society by the Iowa Association of Pathologists. In addition, representatives of the IAP have suggested that Iowa pathologists should assist as possible in instances where participants in the PEP program might be encountering difficulty.

The Committee is pleased to acknowledge the educational programs provided around the state by the State Hygienic Laboratory and the Iowa Association of Pathologists.

Three representatives of the Committee on Independent Laboratories form a subcommittee to provide liaison to the Iowa Society of Medical Technologists. No matters have required attention in this area.

G. R. CLARK, M.D., Chairman

#### COMMITTEE ON INDUSTRIAL HEALTH

The ferment at the national level in the industrial safety and health field continues to be apparent. The broad and complex Occupational Safety and Health Act (OSHA) of 1970 called for a National Commission on State Workmen's Compensation Laws. This Commission was instructed to "undertake a comprehensive study and evaluation of State workmen's compensation laws to determine if such laws provide an adequate, prompt, and equitable system of compensation."

This Commission developed 84 recommendations for the state to consider and adopt; 19 of these recommendations are considered essential. Initially, Iowa was found to be in compliance with 8 of the 19 essentials. With the passage of appropriate legislation in 1973, the State of Iowa has now satisfied 17 of the 19 recommendations totally and the other 2 partially. In total, Iowa is in compliance with 33 of the 84 recommendations.

The legislation enacted last year by the Iowa General Assembly improved various medical aspects of the Workmen's Compensation program. For instance, clarification has been made and compensation will be allowed for medical services provided for a job-related injury even though the injury may not be diagnosed or treated for several years after it was incurred.

In 1973 an Industrial Nurses Group was formed and it now has a membership of approximately 30 nurses, most of whom are employed in central Iowa. According to a spokesman for the group, good cooperation has been received from physicians during the organizational process.

The complications and increased work load caused by OSHA continue to cause frustration.

SIDNEY BRODY, M.D., Chairman

#### MD-DO LIAISON COMMITTEE

The activity of the Committee has decreased in recent years, as decisions on relationships between MD's and DO's have shifted to the local level. The chairman of the Committee has continued to consult with individual physi-

cians and institutions that have raised questions regarding MD-DO relationships. The Committee will continue to stand ready to assist whenever and wherever problems may arise.

J. M. RHODES, SR., M.D., Chairman

#### MEDICAL ASSISTANTS ADVISORY COMMITTEE

As Chairman of the Medical Assistants Advisory Committee, I take special pleasure in announcing the re-election of Jeanne Green as a Trustee of the American Association of Medical Assistants. Mrs. Green has been my medical assistant for 24 years. The AAMA represents more than 15,500 medical assistants who work under the direct supervision of licensed physicians. These individuals serve as a direct link between the doctor and his patients, associates, and suppliers of medication and equipment. A main objective of the association at the local, state and national levels is to foster the education and professionalism of medical assistants.

The AAMA, State of Iowa, is an active state chapter, and the IMS is pleased to assist in one of its projects—the printing of its quarterly membership newsletter.

For the past several years, the AAMA/State of Iowa has sponsored a "coffee-bar" at the opening Sunday session of the House of Delegates. Because of a change in the time schedule and meeting format, it was not possible for AAMA/State of Iowa to arrange the function last year; however, a special letter of greeting and best wishes was read to the delegates when the House convened.

In September, the AAMA/State of Iowa held its annual educational seminar in Ames, Iowa, for all medical assistants. Announcement of the conference was made in the JOURNAL OF THE IMS.

J. F. BISHOP, M.D., Chairman

#### COMMITTEE ON MEDICAL MANPOWER

The Committee on Medical Manpower did not meet this year. However, it wishes to acknowledge the passage of a bill to provide for the establishment of family practice residencies in Iowa community hospitals. The bill was passed by the Iowa Legislature on June 15, 1973. In accordance with the law, an Advisory Board has been appointed to advise the Dean of the University of Iowa College of Medicine in the implementation of the program. The IMS has named Ralph L. Wicks, M.D., Boone, to serve as its representative on this Advisory Board. The IMS expects the enactment of this legislation to result in the development of quality family practice residency programs in community-based hospitals, and to provide greater numbers of family physicians for the State of Iowa.

Representatives of the Iowa Medical Society have attended meetings to consider various proposals to ensure that physicians will be available in rural areas. One proposal being developed by the Health Manpower Committee of the Office of Comprehensive Health Planning provides loans to medical students who will agree to practice for a stipulated time in an Iowa community that serves a rural population. In return for that period of practice, the physician's loan is forgiven. The IMS will keep itself informed on this and other similar recommendations, and will be prepared to offer its advice and counsel.

Highlights of a 1972 Iowa Physician's Survey was published in the September and November 1973 issues of the JOURNAL OF THE IMS. The survey was completed by Guru S. Bale, Ph.D., who is a member of the Records and Statistics Division of the Iowa Department of Health.

B. M. MERKEL, M.D., Chairman

#### COMMITTEE ON MEDICINE AND RELIGION

The Committee on Medicine and Religion did not meet in 1973. However, IMS field representatives have been encouraged to continue to visit with county medical society officials about local medicine and religion projects to involve both physicians and clergymen. Information and ideas developed by the AMA Department of Medicine and Religion have been made available to county medical societies, including discussion topics for joint meetings that would be mutually beneficial—e.g., outline of the procedure for local clergy to follow in their hospital work; means of identification of clergy in the hospital; need for a plan to record the faith preference of patients admitted to the hospital; merits of a plan through which clergy are notified that parishioners are patients in the hospital and would like to be visited.

A representative of the Committee will attend the annual AMA Regional Workshop on Medicine and Religion in Chicago, February 23, 1974.

The Committee is pleased to note that David Belgum, Ph.D., a Professor in the College of Medicine and School of Religion at the University of Iowa, will lead a round-table discussion on the subject of "Bio-medical Ethics" at the IMS Scientific Session in Iowa City, April 18, 19, and 20.

The Committee stands ready to assist any county medical society in developing medicine and religion projects at the local level, and would be happy to participate in joint meetings involving physicians and clergymen.

OTTO E. SENFT, M.D., Chairman

# COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE

No specific items were referred to the National Emergency Medical Service Committee for its consideration during the past year. However, representatives of the Committee attended a one-day conference hosted by the IMS Committee on Safe Transportation involving representatives of the Department of Public Safety, the Iowa Highway Patrol, the State Department of Health, and the Bureau of Criminal Investigation. Of special interest was a discussion of legislative proposals relating to ambulance standards and ambulance services.

The Committee on National Emergency Medical Service will continue to serve on a standby basis and will cooperate with departments of state government which are involved in civil defense programs and those concerned with natural or man-made disasters.

R. C. LARIMER, M.D., Chairman

#### COMMITTEE ON ONCOLOGY

In this brief report it is appropriate to mention the creation in 1973 of the Cancer Epidemiologic Research Center in Iowa. The new Center is headquartered at the University of Iowa and has as its purpose assisting and stimulating projects by others relating to cancer etiology and control. The Center is under the direction of John W. Berg, M.D.

Dr. Berg has met with the IMS Board of Trustees and has corresponded with the chairman of the Committee. He indicates tentatively the new program will include continued surveillance of Iowa cancer incidence and encouragement of hospital cancer programs and cancer registries. In addition, particular emphasis will be placed on the expansion of current control efforts in the state.

An article prepared by Dr. Berg entitled "Cancer in Iowa—1970: A Preliminary Report on Frequencies and

Trends" appeared in the February issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

The Society received information from the AMA late in 1973 advising of stepped up efforts to establish and maintain liaison between the AMA Advisory Committee on Cancer and corresponding committees of state medical societies. Preliminary information requested by the AMA has been provided.

G. R. CLARK, M.D., Chairman

#### COMMITTEE ON ORGAN TRANSPLANTATION

This Committee has considered a number of topics this past year but has focused its attention on cadaver organ recovery. The transplant activities at the University of Iowa Transplant Center continue apace and at present the total is 120, which combines the number of living related and cadaver transplants. The tempo of cadaver organ recovery has increased; however, it has not kept pace with the accession of patients' on maintenance dialysis. We should do 75-100 cadaver transplants a year which would require at least 50 cadavers for this supply of acceptable organs. There are more than enough suitable cadaver donors available in the state each year, but few are identified to the Transplant Team. We hope that enough organs can be recovered to prevent any need for legislation which might compel a larger number of recoveries. A mechanism is available to compensate physicians and hospitals for the recovery of cadaver organs. We would like to present the needs and the present status of cadaver organ recovery to the Executive Council and perhaps ultimately to the entire membership to obtain suggestions for improving the frequency of cadaver organ recovery. This past year satisfactory organs have been obtained from Council Bluffs, Waterloo, Cedar Rapids, Spencer, Des Moines, Sioux City and Iowa City.

Cerebral death was discussed at length and Dr. Bakody has some evidence that national standards may be forthcoming. A bill is pending in the legislature which would define cerebral death. It was the consensus that emphasis should be placed on public education through the Kidney Foundation, the State Board of Health, and the medical societies. The Renal Disease Commission has been helpful in disseminating information regarding need for organ recovery. Criteria have been developed for participants in the transplant program.

The role of the recently formed Renal Physicians Association has been discussed. It is urged that medical societies review the need for such organizations, and sense the urgency of participation in promulgating guidelines for recent legislation which pertains to funding of Renal Disease under Medicare (HR-1). This is mini-national-health legislation, and will be a model for subsequent "MAXI" legislation which is predicted to appear in the next 18 months.

An Organ Recovery Workshop has been developed and is available to interested physicians.

R. L. LAWTON, M.D., Chairman

#### COMMITTEE ON PARAMEDICAL SERVICES

The Committee on Paramedical Services has not been active this year. It should be noted however that various other special committees of the Society are directing attention to matters involving paramedical workers.

For example, the Committee on Physicians' Assistants will present an update on developments in this area. The State Board of Medical Examiners is now exercising its jurisdiction over these paramedical workers. In addition,

the College of Medicine is offering a two-year PA training program which has approximately 25 students.

Liaison is maintained with several allied or paramedical groups through the Iowa Health Council, an organization which includes the nurses, pharmacists, podiatrists, dentists, etc. In February the IHC sponsored its annual dinner for members of the Iowa General Assembly.

The Society continues to receive requests from various groups for assistance in publicizing meetings or special projects. Efforts are made to be supportive whenever possible. The IMS JOURNAL continues to present information on the activities of the Iowa Chapter, American Association of Medical Assistants.

Career information is provided routinely to young people who inquire of the Society about various health fields.

J. T. Вакову, М.D., Chairman

#### COMMITTEE ON PHYSICIANS' ASSISTANTS

The Committee on Physicians' Assistants has not been called upon to consider any matters during the past year, but the members have been kept apprised of developments relating to the training and utilization of PA's at the state and national levels.

An effort has also been made to inform the general membership about PA programs. Three articles appeared last year in the JOURNAL OF THE IMS—a special "In the Public Interest" section on progress which has been made (February 1973); a report from the State Board of Medical Examiners concerning the number of individuals seeking certification as PA's (August 1973); and an interview with A. W. Horsley, M.D., and T. D. Aschenbrener, R.P.A., regarding the PA Training Program instituted at the University of Iowa College of Medicine (April 1973).

The chairman of the IMS PA Committee also serves as chairman of the Advisory Committee on PA's to the State Board of Medical Examiners. In accordance with Iowa law, the BME is to approve programs for the education and training of PA's, and the program established at the U of I has received approval.

The Board also has authority to approve applications of PA's to perform medical services under the supervision of a physician. The following information regarding approval of applicants should be of interest to the membership:

"Applicants for approval as PA's must show they have a preliminary education equivalent to at least four years of study in high school or other secondary school. They must be of good moral character and be a graduate of a program for the education and training of PA's approved by the AMA, or present other evidence of equivalent education, experience and training.

"If the applicant is not graduated from an approved program, he or she will be referred by the BME to the University of Iowa for an evaluation of his or her educational preparation, previous experience and training, and will be required to pass an equivalency examination with written, practical and oral phases.

"The approval of an application for a PA to work under the supervision of a physician shall be granted on a year to year basis. When a nationally recognized certifying examination is approved by the Board, all PA's will be required to pass this test."

The AMA has developed guidelines for physicians on the employment and use of physicians' assistants, and copies are available to individual members on request.

J. K. MACGREGOR, M.D., Chairman

#### PRECEPTORSHIP COMMITTEE

In mid-February, the Preceptorship Committee met with representatives of the University of Iowa College of Medicine to discuss implementation of the two-week preceptorship program which medical students are required to complete in the third year of medical school. The program is now considered an interdisciplinary course and will be operated in the manner of other disciplinary courses. A Preceptorship Advisory Committee to the College of Medicine has been formed, consisting of three faculty members, three medical students, and three primary care physicians, including two members of the Society's Preceptorship Committee.

At the completion of his preceptorship, each medical student prepares a report in which he evaluates the quality of his experience, and a copy is provided to the physician who served as his preceptor.

The Committee maintains its interest in the MECO Program (Medical Education and Community Orientation) of the Iowa Chapter/Student American Medical Association. MECO is a summer job-education project instituted over four years ago to place freshmen and entering freshmen medical students in community hospitals during vacation periods to increase the scope of their education and to stimulate their interest in practicing in smaller communities. The program is endorsed by the IMS, Iowa Academy of Family Physicians, Iowa Hospital Association and College of Medicine.

The Committee feels it would be beneficial and desirable to structure a one-week preceptorship with a physician in the community as a part of the MECO Program; also, that all first year medical students should be encouraged to participate in a one-week preceptorship with a primary care physician, on an elective basis. A specific recommendation in this regard has been transmitted to the College of Medicine's Preceptorship Advisory Committee and MECO Advisory Committee.

A new program is being initiated at the College of Medicine, through the Office of CME, wherein faculty members will serve as "preceptees" to physicians in private practice in order to provide them an opportunity to learn about problems confronting physicians at the local level. It is anticipated that the "host preceptor" will then be invited to the College of Medicine to spend additional time with his "preceptee." The Committee has endorsed this continuing education activity.

A report on the 1973-74 preceptorship program will be published in the April 1974 issue of the Journal of the Ims. The Committee has been assured by faculty representatives that it serves an important advisory role in the continuing evaluation of and improvement in the preceptorship program for University of Iowa medical students.

L. D. CARAWAY, M.D., Chairman

#### COMMITTEE ON QUACKERY

The Committee on Quackery is keeping itself apprised of legislative developments relating to a bill under consideration in the Iowa General Assembly which would expand the chiropractic practice act to allow chiropractors to manipulate the entire musculoskeletal structure, and to use other modalities. The IMS has presented testimony in opposition to this legislation.

At the direction of the State Board of Health, a special chiropractic study committee was appointed by the Commissioner of Health last fall, comprised of two M.D.'s, three chiropractors, a physical therapist, and an educator.

As a result of its study, the Committee expressed opposition to the proposed legislation which would liberalize the practice of chiropractic, contending that the Palmer School of Chiropractic in Davenport does not adequately prepare its students to administer expanded treatment. The Board of Health approved the study committee's report, but has indicated it would be "receptive" to recommendations and suggestions with respect to improving chiropractic education.

The IMS has on file a complete copy of the report, and reprints have been provided to members of the IMS Committee on Quackery.

Last October, Thomas Ballantine, M.D., Boston, Massachusetts, Chairman of the AMA's Committee on Quackery, participated in the Iowa Health Council's Leadership Conference, and discussed the subject "Chiropractic and P.L. 92-603." The manuscript of Doctor Ballantine's excellent presentation was published in the January 1974 issue of the JOURNAL OF THE IMS.

In July, the IMS commented on the proposed standards and regulations pertaining to the inclusion of chiropractic under Medicare. In a communication to the Secretary of the Department of Health, Education and Welfare, the Society commented that "medicine does not adhere to the philosophy expressed by chiropractic that there can be two separate approaches to the treatment of human ailments . . . and the inherent dangers to the American public of giving credence to a healing philosophy which has no basis in scientific fact should be obvious."

Last May, two members of the Committee and staff attended an AMA Regional Conference on Quackery held in Madison, Wisconsin. The state societies of Illinois, Ohio, Minnesota, Michigan, Indiana, South Dakota, and Wisconsin were also represented.

The Committee is pleased that one of its members, C. H. Denser, Jr., M.D., Des Moines, continues to serve on the AMA Committee on Quackery.

W. R. WHITMORE, M.D., Chairman

#### COMMITTEE ON RURAL HEALTH

The Committee on Rural Health has not met this past year. However, it should be noted that the chairman also serves on the Delivery of Health Services Committee. These two Committees have overlapping interests in assuring the availability and accessibility of health care in rural areas.

As noted in the report of the Committee on the Delivery of Health Services, there has been a delay in planning and arranging a series of regional meetings for the purpose of discussing long-range health plans for the various areas in the state. It is anticipated that the project will be implemented at the earliest possible date, and members of the IMS will be kept apprised of any further developments.

The Committee chairman will represent the IMS at an AMA National Conference on Rural Health to be held in Detroit, Michigan, April 25-26.

M. E. Olsen, M.D., Chairman

#### COMMITTEE ON SPORTS MEDICINE

The Committee on Sports Medicine will present its second Conference on the Medical Aspects of Sports on April 4 at the Des Moines YMCA. The conference is for coaches, trainers, physicians and other interested persons. A 1972 conference was attended by 300, and it is hoped a similar number will attend this year's meeting.

Co-sponsors of the 1974 conference are the Iowa High

School Athletic Association and the Iowa Chapter, American College of Pediatrics.

Keynote speaker for the meeting will be Fred L. Allman, Jr., M.D., who heads the Sports Medicine Clinic in Atlanta, Georgia. Dr. Allman is a past-president of the American College of Sports Medicine.

Topics on the one-day program include physical injuries, conditioning, summer fitness programs, weight matters, attitudes and conduct. A special taping clinic will be offered with demonstrations by trainers from the University of Iowa, Iowa State University and Drake University.

The Committee has discussed further the need for a stepped-up program of gathering athletic injury information. This matter will be explained to the coaches attending the April 4 conference.

The Committee has been advised by the Iowa High School Athletic Association that use of the physical examination form devised by the Committee continues to increase. This form has been available for optional use for several years. Use of the form has been urged by the Committee on a mandatory basis, but such a requirement has not been instituted. An In the Public Interest feature in the June 1973 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY described the form.

The Committee calls attention to a new book compiled by the American Medical Association entitled "Comments in Sports Medicine." Single copies are available for \$5 from the AMA. Also in the publication area, the Committee is pleased to note the inclusion of an article by C. M. Tipton, Ph.D., and Tse-Kia Tcheng in Medicine and science in sports entitled "Iowa Wrestling Study: anthropometric measurements and the prediction of a 'minimal' body weight for high school wrestlers."

R. W. Anderson, M.D., Chairman

# COMMITTEE ON VOLUNTARY HEALTH AGENCIES

Even though no meetings of the Committee on Voluntary Health Agencies have been held in 1973, it is appropriate to report that the Society continues to maintain liaison with these important organizations.

It is customary in this brief report to commend the good efforts of many Iowa physicians who provide leadership and medical expertise to the voluntary agencies. We encourage Society members to allocate some portion of their time to assisting worthy organizations in the health field.

Various requests are made of the Society by different organizations during the course of a year. For example, the Iowa Society for the Prevention of Blindness has asked the cooperation of the IMS in promoting a free home eye test for preschool children. This effort is in addition to other preschool vision screening programs of the Iowa Society for the Prevention of Blindness and is endorsed by the organization's medical advisory committee.

A further illustration of cooperation involves efforts by the Society to enlist a member physician to serve as a medical representative on the board of the Iowa Chapter of the Myasthenia Gravis Foundation.

Matters of concern to physicians are also given attention. For instance, the Epilepsy Society of Area XI has undertaken a survey of epileptics in central Iowa this year. An interested IMS member suggested the survey would receive better support from physicians in terms of encouraging patients to respond if the Society was informed in advance of the project. Contact is being made with appropriate officials to increase cooperative possibilities with the Epilepsy Society.

The AMA Directory of National Voluntary Health Organizations is kept on file by the Committee and is referred to as requests for information are received by the Society.

C. E. Schrock, M.D., Chairman

#### WOMAN'S AUXILIARY ADVISORY COMMITTEE

The Advisory Committee to the Woman's Auxiliary reports that Iowa's organization for physicians' wives continues active participation in and support of projects in its assigned areas. The Auxiliary members have cooperated with county medical societies and the state society in various programs, as their services were asked for or needed by the parent organization.

The Auxiliary is striving to overcome those traits and practices which have traditionally characterized women's groups, and are making every effort to win recognition not only from the medical profession but from the lay public as well. Continuing growth on this basis is certain to enhance the image of the physician and the physician's wife through her work in the community and to emphasize her serious concern in helping her physician-husband provide medical leadership to create a better world through better health.

Iowa's Auxiliary continues to receive recognition on the National Board of Directors. Mrs. Max E. Olsen is a Board member and also serves as WA-SAMA liaison. Mrs. Howard Ellis is National Communications chairman.

Various committee activities and functions are listed.

#### 1. AMA-ERF

A. Collection of funds through a variety of projects and solicitation of contributions and memorials. (The U. of I. College of Medicine receives a yearly gift from the national organization and students have access to loan funds.)

B. Over \$10 per member was obtained for this purpose last year.

#### 2. Legislative Committee

A. Receives direction and assistance from the national auxiliary.

B. Annually entertains wives of legislators and state officials at a brunch. This affair is popular with these ladies and excellent contacts are made and maintained thereby.

C. In addition to the legislative chairman, three more officers are now regular members of the IMPAC Board.

#### 3. Health Services Committee

A. Promotes community participation in four areas. (1) The abused and battered child, (2) Safety at home and on the highway, (3) Gems and Block Mother Plan, including the elderly, (4) Blood Donor programs.

#### 4. International Health Committee

- A. New Eyes for the Needy
- B. Church World
- C. Care
- D. Hope Ship
- E. World Health
- F. Yucatan

Yucatan is Iowa's Sister State and medical supplies and equipment are collected and sent for use in hospitals of that area.

#### 5. Community Service Committee

A. "Volunteer Health Service Award" presented each year to an outstanding woman whose service to health projects deserve such recognition.

B. Selling products which are made by homebound handicapped.

#### 6. Mental Health Committee

A. Distribution of mental health materials with emphasis on learning disabilities.

B. Publication of articles in the Auxiliary News on various aspects.

#### 7. Nutrition Committee

A. This is a new committee and is active in the study of and distribution of ideas on such aspects as cholesterol and low calorie nutritious foods.

#### 8. Ecology and Rural Health

A. This committee is active in distribution of material in the area of venereal disease control and other environmental problem areas.

#### 9. Health Education and Loan Fund

A. Assists deserving young people in their pursuit of education.

B. Maintains contact with schools of nursing and area colleges to promote the loan fund.

C. Funds in excess of \$29,000 are being used for this purpose.

The Auxiliary publishes an excellent newsletter which is distributed to its members each month. This keeps members informed of officers' activities as well as providing information of various county activities.

The officers and committee chairmen and committee members are dedicated and enthusiastic in their various projects which are designed and directed toward promoting better health and medical care to the people of Iowa and the nation and the world. The Committee urges IMS members to support the Auxiliary by encouraging 100% membership and soliciting their assistance in the solution of public relations and other problem areas. The dues are nominal and the rewards are sufficient to justify the effort.

RALPH L. WICKS, M.D., Chairman

(This concludes the material published in the handbook for the house of delegates.)

# Supplemental Reports BOARD OF TRUSTEES

Presented by J. F. Bishop, M.D., Chairman, Board of Trustees

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business. Section 4, referred to Reference Committee on Articles of Incorporation and By-Laws.)

Just seven months ago, the House of Delegates met here in "Regular Session" to consider and act on several items of major importance to the medical profession, including two dealing with the continuing operation and the organizational structure of the Iowa Medical Society.

Specifically, in response to a report from a special study committee which undertook an in-depth analysis of IMS finances, a membership dues increase was approved, which became effective in January. I am pleased to tell you the membership, in the main, has responded as we anticipated it would . . . with continued support and nary a grumble. Well, maybe one or two.

Action was also taken to reapportion the House of Delegates to the satisfaction of all county medical societies. Amendments to the By-Laws were approved which retain the right of every component society to be represented in the House by at least one delegate for each county within the component society; in addition, a formula was established whereby a component society is entitled to one additional delegate for each additional 15 active or life members, or major fraction thereof.

At our meeting last October, we took stock of IMS involvement in several important areas of concern: our support of private enterprise financing of health care; our endorsement of worthy health legislation, and our opposition to bills that are not in the public—or the professional—interest; our leadership in establishing an effective and functioning peer review mechanism; our interest in advancing quality medicine and medical knowledge through continuing education programs; and our over-riding objective of assuring the lowa physician his position as captain of the health care team, and obtaining an equitable reimbursement for physician services, along with a free practice environment.

Since detailed reports were presented in October regarding IMS activities and involvement, the Board of Trustees does not wish to take the time to rehash old news. However, there are several developments and recommendations which do require your knowledge and action:

1974 SCIENTIFIC SESSION: First, on behalf of the officers and the membership, I want to compliment Dr. Rubin Flocks, IMS President, and the members of the 1974 Program Committee for arranging a very excellent scientific session in Iowa City last month. The program was designed to permit active participation by the 235 physicians who attended. It was truly a valuable continuing medical education experience for the practicing physicians of the State.

FINANCES: During 1973, the Board of Trustees submitted a comprehensive financial report to the Spring House of Delegates meeting. The House created a special Interim Study Committee/IMS Finances which conducted an intensive review of IMS fiscal posture. This special committee reported its recommendations to the October meeting of the House of Delegates. Based on the study, the House increased annual membership dues for the first time since 1969, while at the same time suggesting the Board continue its efforts to economize and curtail expenses when and where possible, without sacrificing the high standards established for implementing all Society projects and services.

The Board of Trustees is pleased to report the increase in income from 1974 dues will, for the first time in several years, point the Society toward a position of eliminating deficit financing. In 1973 the purse strings of the IMS were pulled as taut as feasible. The membership in 1974 has held steady, which, in the judgment of the Board, indicates that Iowa physicians support a strong medical association with a unified voice.

The Board has established a 1974 budget which will permit the Society to continue, and perhaps slightly expand, many essential programs. Based on projections for 1975, it is very likely the necessity for borrowing funds can perhaps be completely eliminated, and starting in 1976 it is hoped actual depreciation funds can be set aside for future needs.

PHYSICIAN'S ASSISTANTS: Late in March representatives of the Board of Trustees and the Society's Committees on Physician's Assistants and Delivery of Health Care met with members of the State Board of Medical Examiners to discuss some of the problems and questions that have arisen with respect to the utilization of physician's assistants in Iowa. The Board of Medical Examiners has drafted a set of rules and regulations governing what can and cannot be done by PA's, and another joint meeting will be held later this month for further review and discussion. The goal of the PA program in Iowa is to enhance the productivity of the physician, and to extend the physician's capabilities in the diagnostic and therapeutic management of patients.

M.D.-NURSE LIAISON: There is a great deal of activity taking place in the nursing arena, especially with respect to extending the role of the nurse in patient care. Just recently, a bill developed by the Department of Health was introduced into the Iowa House of Representatives which calls for the establishment of health service centers for delivery of health care by public health nurses.

The Board of Health has directed the Commissioner of Health to appoint a committee to study the use of nurse practitioners in public health programs, and the IMS has been invited to designate a physician to serve.

The IMS is being invited to join with the Iowa Hospital Association in a one year pilot project to be funded by the Iowa Regional Medical Program, whereby 6 nurses will be selected to receive additional training as "family nurse practitioners" and be placed in satellite clinics to serve under the supervision of physicians. It is understood the individuals who participate will be required to pass the physician's assistant examination prior to serving in a satellite clinic. The objective of this project is to "evaluate the ability of the family nurse practitioner to deliver health care in the rural areas under the doctor's supervision."

It should be noted that originally the IHA was designated as the only sponsor of this project, but as a result of recommendations and comments offered by Kenneth Lister, M.D., the Society's official representative on the Iowa Regional Advisory Group, the IMS will have an equal voice in its implementation.

Some members of the nursing profession are also interested in exploring "independent practitioner" status for nurses.

In light of these developments, the Society's Committee on Delegation of Authority will meet with representatives of the Iowa Nurses' Association and Iowa State Board of Nursing at an early date. This liaison group will discuss the broad subject of the expanded role of the nurse, and what is being considered with respect to specific programs and/or legislation.

AMA/CURRENT PROCEDURAL TERMINOLOGY: At its meeting last April the House of Delegates urged all physicians to use the five-digit coding system as described in the AMA's Current Procedural Terminology. As a result of that action, the IMS and Blue Shield are cooperating in a venture to provide a free copy of the CPT to every doctor in the state. Some will be mailed, and others will be hand-delivered by IMS/Blue Shield field representatives. If the CPT coding and nomenclature are used routinely by physicians and their office personnel on all third party claims, a more accurate and prompt claims processing system can be achieved, and the establishment of continuing reliable fee profiles will be assured.

HOSPITAL/MEDICAL STAFF RELATIONS: In January, Betty J. Anderson, Assistant to the Legal Counsel of the American Medical Association, appeared before the Executive Council and presented a comprehensive and en-

lightening commentary on hospital/medical staff relations. She stressed that the organized hospital medical staff must be delegated the responsibility for all medical matters. She also stated that if hospital control over medical practice is to be thwarted and physician responsibility retained, the proper functioning of the organized staff must be assured; and the medical society, at all levels, should be prepared to provide expert assistance in disputes between hospital boards and medical staffs.

The full text of Miss Anderson's discussion appeared in the February 1974 issue of the IMS JOURNAL, and it is a

paper all physicians should take the time to read.

FILM ON MEDICAL CARE DELIVERY: In response to an invitation from the Iowa Regional Medical Program, James Kimball, M.D., Osceola, has been designated as a representative of the IMS to serve on an advisory committee that will assist in the development of a community education film dealing with alternate arrangements for the delivery of health care. The film is being funded by IRMP, and produced by the Family Practice Department of the University of Iowa College of Medicine.

It appears that the main thrust of the film will be to consider a regional system for delivering primary and secondary health care in the state, and to illustrate educational methods presently underway to motivate medical students toward rural practice.

The film is to be made available for use by medical societies, hospitals, civic organizations, television stations, and other interested groups.

UNIFIED MEMBERSHIP (COUNTY, STATE, AMA): The AMA has contacted all state medical societies requesting consideration of a "unified membership" which requires a physician to belong to his state medical society and the AMA if he is a member of his county medical society. According to the AMA, six states currently have the unified membership provision.

In the opinion of the Board of Trustees, it isn't necessary for the IMS to consider such a program at the present time since 94% of our members also belong to the AMA and Iowa physicians, in general, are supportive of organized medicine and recognize the value of a unified profession.

**ACTION ITEMS:** In addition to the background information just presented to you on current activities and concerns, the Board of Trustees wishes to submit the following four items for your consideration and action:

1. House of Delegates' Meeting Schedule: The schedule for meetings of the House of Delegates is arranged so as to provide sufficient time and opportunity for discussion and debate on the various reports and resolutions. The Board of Trustees and the Speaker of the House of Delegates have long felt that requesting physicians who have assumed responsibility as county medical society delegates to take two to two and one/half days from their busy schedules, once or twice a year, is not asking the impossible, especially when you consider the amount of work that needs to be accomplished during meetings of the House; i.e., the actual presentation of reports and routine business matters; open reference committee hearings; executive sessions for reference committees, and the actual presentation of their reports; the technical job of typing, reproducing, collating and packaging the reports; and final consideration and action on the recommendations of the reference committees.

The IMS is not a "peanut" operation. It is a professional, sophisticated, well-organized association that has problems of major significance with which to contend. The actions taken by you, as representatives of your colleagues back home, will have a great impact on the manner in which medicine is practiced now and in the future, and on the role of the medical society as an influential force in the health care field.

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The Board is hopeful the House is satisfied with the present meeting arrangements; if not, we shall, of course, be responsive to your wishes insofar as any proposed changes are concerned.

2. Student Iowa Medical Society: The Board is pleased that the Student Iowa Medical Society is about to become a fait accompli, subject to House approval of a recommendation from the Judicial Council that a charter be issued to SIMS as a component society. In light of information received from representatives of the medical class at the University, as well as from other state medical societies, the Board of Trustees submits the following resolution:

Resolved, That dues for student members of the Iowa Medical Society are hereby established at \$5.00 per stu-

dent member to be paid one time only.

3. IMS Membership Dues: In view of the recent study of IMS finances, the Board of Trustees has received House approval and guidelines for its future fiscal planning. Based on these guidelines, the Board of Trustees recommends that IMS dues for 1975 be established at \$200.00 per member.

4. Dues for Physicians in Their First Two Years of Medical Practice: Recognizing that physicians just starting in practice are sometimes reluctant to become active in organized medicine because of the financial investment involved, and in an effort to stimulate immediate membership and active participation of new practicing physicians in the Iowa Medical Society, the Board of Trustees

proposes the following:

Resolved, That the annual per capita dues of an active member of the Iowa Medical Society who is engaged in his or her first two years of active practice are hereby established at one-half of the dues charged other active members, and that the term "first two years of active practice" shall mean practicing as a physician for remuneration in any capacity, in or outside the State of Iowa, after graduation from medical school but not including practice as an intern, resident, member of the armed forces or in service alternative to that in the armed forces.

IOWA FOUNDATION FOR MEDICAL CARE: The Board of Trustees wishes to take this opportunity to reiterate IMS support of the Iowa Foundation for Medical Care for designation by HEW as the Professional Standards Review Organization (PSRO) for the State of Iowa. We are fortunate that in light of the legislative actions that have been taken, the Foundation exists and is actually carrying out an effective peer review program which is mutually beneficial to the public and the profession. In order to bring you up-to-date on recent PSRO developments and other activities, I am pleased to introduce John Sunderbruch, M.D., President of the Foundation, who will present an informational report.

#### IOWA FOUNDATION FOR MEDICAL CARE REPORT TO IMS HOUSE OF DELEGATES

J. H. Sunderbruch, M.D., President

Thank you Dr. Bishop. It is my pleasure to present this 1973-74 informational report on the Iowa Foundation for Medical Care. The report is submitted on behalf of the Foundation Board of Directors.

The Iowa Foundation for Medical Care has been in the spotlight a good bit this past year. Many physicians regard the Foundation as the step-child or offspring of that somewhat infamous law calling for the creation of Professional Standards Review Organizations, or PSROs. This is to be expected since the Foundation is the logical PSRO candidate in Iowa. The Foundation has authored

and sponsored various communications to acquaint medical staffs and hospitals with the provisions of the new law. However important, the Foundation's PSRO explorations should not be allowed to overshadow the progress made in the first full year of operational activity in peer review.

During the calendar year 1973, the Foundation was requested to review 899 cases. Of these, 683 were fully resolved and 19 were appealed to a higher level of review. The success of the peer review program to date stems directly from the active involvement of the six district committees. Under the excellent direction of able committee chairmen and co-chairmen, these conscientious committees have devoted an estimated 500 hours of professional time in full meetings and in one-on-one review. The only remuneration paid to these reviewers has been

for travel expenses and supplies.

The Foundation has demonstrated to physicians and to third parties its capabilities as a peer review mechanism. All physicians have been and are encouraged to use the Foundation in situations where a dispute arises over the cost or necessity of a particular medical service. This may be accomplished through direct contact with the Foundation office or by requesting a third party insurer to forward the case on to the Foundation. Either way, we request that physicians volunteer all pertinent medical information so that committees may properly consider the total circumstances. In this way fair and equitable decisions will result.

I am pleased to report a 1973 expansion of the Foundation's peer review system to include other providers of health care. Through an agreement reached with the Iowa Podiatry Society, the Foundation has now incorporated podiatry review into the present review activities of the Foundation. In addition, the Foundation has also interfaced with the Iowa Dental Association and their system of peer review. The addition of these provider review systems now permits the Foundation to offer a broader assurance of the delivery of quality health care at an equitable cost.

The impact of the Foundation is being felt in all areas of health care delivery and financing. Because of its expanded role in the medical community, the Foundation Board of Directors, this past year, voted to create an Advisory Committee to act as a sounding board on matters which affect all aspects of health care delivery. The Advisory Committee is made up of representatives from the following organizations:

Iowa Hospital Association
Iowa Podiatry Society
Iowa Dental Association
Iowa Optometric Association
Iowa Pharmaceutical Association
Blue Cross-Blue Shield
Health Insurance Association of America
Office of Comprehensive Health Planning
Health Facilities Association of Iowa
John Deere Insurance

This Advisory Committee will be encouraged to transmit its comments and reactions to the Foundation's Board of Directors, and thus will have a role to play in the decision-making process.

The Foundation recently distributed a pamphlet to all IMS delegates and alternate delegates which describes (1) the Foundation's activity as a peer review organization and (2) its potential role as a PSRO. It is hoped the question-and-answer format will facilitate physician understanding and respond to concerns you have about Foundation involvement in those important areas.

Shortly after the PSRO Law was enacted in 1972, the Executive Council of the Iowa Medical Society directed the Foundation to weigh the merits of seeking the PSRO designation for Iowa. Since then, the Foundation has sought guidance from the Council and has kept it apprised of important developments as they have occurred.

In June, 1973, the Foundation sponsored a PSRO briefing session. This was conducted in co-operation with the Iowa Medical Society and the Iowa Hospital Association. Approximately 200 representatives of medical staffs and hospital administration attended the session. Included in the program were spokesmen from HEW, the American Hospital Association and the American Medical Association.

In October and November of 1973, the Foundation sponsored five regional seminars for hospital medical staffs. Presentations were made by representatives of hospitals where quality assessment programs are functioning. In addition, the seminars included explanations on the various services available to hospitals to assist them in developing their own quality review programs. Total attendance at the five seminars exceeded 400.

Actual preparation for the implementation of PSRO began last summer when the HEW Regional Offices conducted hearings throughout the country to determine the area jurisdictions. The hearing on area designation in Iowa was held in August at the Iowa Medical Society. The desire of the Iowa Foundation to have the State of Iowa designated as one PSRO area was expressed at the hearing. The Foundation was supported in its urging of statewide designation by 18 health-related organizations. In April of this year the area designations were finalized and published in the FEDERAL REGISTER. As I am sure you already know, Iowa was designated for a single PSRO.

It should be pointed out that the Iowa Foundation for Medical Care was created by this House of Delegates in 1971 before Public Law 92-603. Since its creation, the Foundation has developed a viable system of peer review and has gained the support of a large percentage of the physicians in the state. The PSRO law virtually mandates the Foundation to pursue PSRO designation in Iowa; the Foundation's rightful claim as the profession's peer review instrument makes this the only reasonable course of action. The law clearly specifies that until January 1, 1976, only a nonprofit professional organization representing most physicians in a given area can qualify as a PSRO. However, if such an organization fails to apply by 1976, HEW may pick any agency it thinks has the competence to conduct the review activities for the government medical service programs. It is this last point that concerns the Foundation Board of Directors and makes important the present Foundation action to seek designation as the PSRO for Iowa.

The Iowa Foundation is not attempting to convince Iowa physicians that federally mandated peer review is highly desirable. Rather, the Foundation Board of Directors continues to urge Iowa physicians to use the expertise and resources of the Foundation, the Iowa Medical Society, and the American Medical Association in following PSRO developments. Because PSRO is the law of the land, the Iowa Foundation for Medical Care is attempting to act on your behalf to prepare for it.

#### (Resumption of the Report by Dr. Bishop)

BLUE SHIELD: During the past year, changes have occurred within the Blue Cross/Blue Shield organizational structure which will be reported to you by Christian E. Radcliffe, M.D., President of Blue Shield. Sam Leinbach, M.D., Chairman of the Blue Shield Board of Directors, will also address the House briefly. As Dr. Radcliffe

comes to the podium, I would just like to acknowledge the fine relationship which exists between our organizations, and the close communication maintained between the officers and staff.

# BLUE SHIELD REPORT TO IMS HOUSE OF DELEGATES

C. E. Radcliffe, M.D.; President, Blue Shield of Iowa

Please permit me to express appreciation on behalf of the Blue Shield of Iowa Board of Directors for this opportunity to present our annual report to the Iowa Medical Society House of Delegates.

A great deal has happened since we made our traditional report to the House 12 months ago. As the 20th largest Blue Shield Plan in the nation in 1973, we paid \$80.4 million in medical and surgical benefits through our regular lines of coverage and through our public service role as a fiscal intermediary for various governmental health care programs.

Blue Shield membership in the state reached 1,130,013 regular business participants at the end of 1973. This represents a sound growth of 37,000 members over the previous year. As of March 31, 1974, we have 1,138,509 participants. The Iowa physicians who founded Blue Shield many years ago were far-sighted individuals. They deserve our continued acknowledgement.

Blue Shield paid \$52 million for physicians' services rendered to Iowans covered by the regular Blue Shield contracts last year. This represents an increase of \$1.8 million in medical payments over the previous year.

Add to this another \$20.8 million disbursed for physicians' services under the Part B Medicare Program, \$670,000 under the CHAMPUS Program for military personnel, and \$6.7 million for physicians' services under the Medicaid Program, and you have the \$80.4 million I mentioned earlier.

Although we must adhere to strict government regulations, as onerous as they sometimes might be, in the Medicare, Medicaid, and CHAMPUS Programs, we believe our involvement in this area, as encouraged by the IMS House of Delegates, has been beneficial to the medical profession and the patient. You may rest assured, we will continue our effort to encourage federal and state government to be conscious of the need to preserve the freedom of the physician and to be responsive to the ever-changing health needs of the public he serves.

The continuous involvement and support of the Iowa Medical Society, the mix of practicing physicians and lay representatives on the Blue Shield Board of Directors, our fine relationship with Iowa physicians, plus a very capable administrative staff headed by Mr. Bill Recknor, has resulted in a number of accomplishments over the past 12 months.

The consolidation of our Blue Cross and Blue Shield services has resulted in a substantial financial savings to the benefit of both physicians and subscribers. I might divert here just a moment to say that we have melded to a degree with Blue Cross, but your representatives on the Board of Blue Shield are going to see to it that we are individual corporations. We, I and the rest of your members, are your representatives, and the people that are on the Cross side are the hospital representatives, and we are concerned about your interests, practice, and so on. At the present time medical men comprising the Board of Directors of Blue Shield are 19, and lay members are eight, and they have contributed very valuably to the operations of the Board.

In April of this year, the Plans implemented the second step in strengthening the Blue Cross and Blue Shield management team. The basic reason for our existence is the welfare of the patient, and getting the most out of the dollar has never been lost sight of.

We have achieved many of our objectives in less than a year. This effort has helped to identify other structural changes that are needed before we can attain our overall goal of excellence. We are working at all of these.

The Joint Management Committee with guidance from the Blue Cross and Blue Shield Boards has identified three areas that we should have as our major concern during 1974.

1. Improve the Plans' service to subscribers and providers through increased internal effectiveness.

2. Contribute to changes in the health delivery system through close cooperation with hospitals and doctors to implement recent and forthcoming legislation.

3. Develop planning for our involvement in the event that National Health Insurance is enacted by Congress.

Most of the following Blue Shield of Iowa activities are in direct response to requests from the IMS House of Delegates.

The Plan has continued to upgrade its low level surgical medical contracts as asked by this House of Delegates. This ongoing effort has resulted in a total of 811,179 participants with UCR benefits. This is 84 percent of the Blue Shield members under age 65. Only 152,819 participants under 65 years of age still have contracts other than UCR.

In December the Plans announced one of the first quarter million dollar Major Medical Programs in the system. The new coverage, introduced at no additional cost to members, now covers over 418,937 people in the state. This benefit, when coupled with our Comprehensive Basic Coverage, is equal to or better than the best prepaid medical, surgical program marketed today.

Study of alternate delivery systems has been encouraged by the Society. Included here, of course, is the health maintenance organization which we prefer to call alternate delivery systems. We have responded to invitations to visit with local physician groups about alternate delivery approaches. We are able to report that consideration of this approach is still preliminary and is being coordinated with Iowa Medical Society's Committee appointed to consult with Blue Cross and Blue Shield as these alternate approaches are explored.

We are pleased to have joined with the Society to embark on the educational phase of a new uniform nomenclature and coding system in Iowa. We refer to our anticipated broad use of the American Medical Association/Current Procedural Terminology. The significant cost of conversion to the five-digit system appears well justified when the long-term beneficial aspects are considered. We heartily endorse the AMA/CPT and commend the IMS and AMA for their leadership in developing this new instrument. We are pledged to working with the Society to foster wide use of the AMA/CPT.

The AMA/CPT is a listing of medical terms and identifying codes for reporting medical services and procedures performed by physicians. Its purpose is to provide an accurate, uniform method of communication between physicians, patients and third parties. Our Claims Department receives claims from Iowa physicians using many different coding and nomenclature systems, and these literally drive our claims examiners "up the wall." Interpreting and translating these different codes and nomenclatures and relating them to our own four-digit system is a formidable task. We join the Society in encouraging Iowa physicians to use AMA/CPT coding and nomenclature on all claims. Specialty groups have themselves been of prime help in the development of CPT.

Many specialty groups have their own mini-version of CPT

We cannot assure you that the government programs such as Medicare and Medicaid which we administer will adopt the AMA/CPT. The reaction from Washington, D.C., and Baltimore has not been enthusiastic. However, we do believe the five-digit code will eventually become the universally accepted system.

The IMS is now embarked on a distribution program to get the AMA/CPT to all Society members. It will take some time for this distribution to be completed. At the present time, approximately one-third of the manuals have been distributed.

This marks the second consecutive year for our public health education advertising campaign. The seven messages dealing with heart disease, cancer, stroke, suicide, alcohol, drug abuse, high blood pressure, medical checkups and respiratory diseases are appearing in newspapers throughout the state. Over 47,000 posters and brochures containing miniatures of the series have been distributed to physicians' offices, hospitals, health agencies, schools, companies and civic organizations in Iowa. The medical profession and the public have reacted very favorably to this educational effort.

In March, we established 12 Blue Cross and Blue Shield Area Subscriber Advisory Committees and a State Subscriber Advisory Council. This 159-member organization with representatives from each of the 99 counties in our State was founded in an effort to expand our input from the users of health care services. Recommendations from these public representatives will be presented to Blue Cross and Blue Shield of Iowa board members serving on the Subscriber Relations Committee. I am pleased to say our initial contact with these community leaders leads us to believe they share a number of the same concerns medicine has over the accessibility and availability of health care services.

Pre-admission testing has grown from a pilot program involving a handful of hospitals to an ongoing service in 21 of the 112 general hospitals in Iowa. Although it is too early to measure the savings generated by this alternative method of delivering services, Iowa physicians deserve a great deal of credit for the arrival of pre-admission testing. Blue Cross and Blue Shield of Iowa stand ready to increase this *PAT* activity to include medical and surgical care in institutions where there is appropriate peer review by physicians.

The 1973 House of Delegates approved a report from the IMS Sub-committee on Medical Review, stating in effect that this Sub-committee, in consultation with the Iowa Foundation for Medical Care, should continue to consider a "statewide customary" by specialty for implementation when deemed appropriate.

Most physicians know the difference between "usual fee" and the "customary" determination. The latter term refers to a fee when it is in a range of usual charges for a given service billed by most physicians with similar training within a given geographic area. It will be helpful if you understand that by "most," Blue Shield refers to the 90th percentile; also, "geographic area" refers to eight geographic areas in the state basically patterned after the seven old 1967 congressional districts, with the eighth being the U. of I. Hospital complex as a separate entity.

The statewide "customary" profile may well eliminate complaints as to possible "favoritism" between specific geographic areas on the one hand, and to bring about more equity to all.

Obviously, the Sub-committee and the Foundation have spent many hours on this subject with specialty groups, individuals, district peer review committees, and the

university physicians and with Blue Shield. Also reports have been made to the Executive Council of the IMS, by both the Sub-committee and the IFMC, encouraging the adoption of the state-wide customary concept.

Blue Shield is sympathetic to the recommendation of the Sub-committee and the IFMC as endorsed by the House. It would appear there may be advantages and disadvantages under almost any system, and it may be impossible to please everyone.

Our actuary has been studying the impact of a "statewide customary" approach, and his report will be presented to the IMS as soon as this information is available,

hopefully in the very near future.

The last item in the Blue Shield report involves another progressive step forward in the mechanics of delivering benefits and processing claims. A new embossed plastic Blue Cross and Blue Shield identification card is being issued to replace the printed plastic card. In addition to a substantial improvement in appearance and resistance to print wear, the raised characters on the new card work well with patient data recording equipment used in offices and institutions.

In closing, I would like to again express my appreciation to the House of Delegates and all IMS members for their part in making these many Blue Shield ac-

complishments possible.

While we are pleased to have been able to report these many achievements to you today, we will not rest on our laurels because we know the future will place far more demands on our energies than we have ever expended in the past. Therefore, we must accelerate our combined effort to provide the best in health care services at a reasonable cost to the people of Iowa.

We know we have a lot of work ahead of us to do yet and we are going to keep working. The Board is dedicated, not only the physician members but the entire Board. Our continued objective is to provide health care service at a reasonable cost to the people of Iowa.

I would like to introduce the well-known Sam Leinbach who has done a tremendous amount of work for the State of Iowa; a staunch supporter of the College of Medicine; served in the AMA as the Rural Health representative from the State for a long while, and is now Chairman of the Board of Blue Shield of the State of Iowa.

#### REMARKS OF S. P. LEINBACH, M.D.

Chairman, Blue Cross-Blue Shield Board of Directors

There is a popular expression used today to describe a person's interests and activities. It goes like this: He's *into* cars!! He's *into* sky-diving!! He's *into* cooking!!

So, in keeping with the times, I offer each of you my sincere and personal commendation for being: Into policy-making for your medical profession.

It's been a genuine pleasure to observe this policymaking House of Delegates for a long number of years. Some of you have shared much or all of my tenure, and the many friendships are treasured by me.

So far as I know, none of us claim to have made all the right decisions. And we probably haven't operated with parliamentary perfection all of the time. But those of you—both veterans and newcomers—who give up valuable time from your separate practices and from your personal lives to represent your medical colleagues deserve much praise and recognition. I personally believe the record we have established is an outstanding one—both for the public and the profession. I am proud to have been a member of the team.

And it has been a pleasure for me to serve on both sides of the fence. The opportunity to serve first as chair-

man of the board and then president of the Iowa Medical Society is one for which I will always be grateful. Then to follow that service by holding similar positions at Blue Shield has obviously doubled my pleasure. Viewing the dynamic health care delivery scene from these several vantage points has been most exhilarating.

Having so served—and having now made the decision to pass the baton to another—I am totally convinced that the exercise has been worth the time and the occasional frustration. We who serve in leadership roles must be willing to receive the criticism and respond to it to the utmost of our abilities. Please allow me to leave that admonition with you today.

The Iowa Medical Society and Blue Shield have performed a unique and extremely beneficial service for the citizens of Iowa and for the providers of health care. Even our most severe critics must admit that our mutual efforts have contributed mightily to the progress and well being of this state.

1974 is, interestingly, the 30th anniversary of the action taken by this House of Delegates to authorize Iowa Medical Service-Blue Shield. The following excerpt from the October 1944 JOURNAL OF THE IOWA MEDICAL SOCIETY SUMS up the action taken on November 1 of that year:

"Shortly, the House of Delegates will be called to special session to consider a prepayment, non-profit medical service plan for Iowa and to place its official stamp of approval upon a final draft. This is perhaps the most important matter that ever confronted Iowa physicians as a group. It is medicine's answer to the demands of the people for security against disaster from catastrophic and unexpected illness. The government proposed to meet the same demand through compulsory insurance.

"There is no question but that medicine's voluntary non-profit insurance plan is vastly superior to any governmental, politically dominated, compulsory insurance program, both from the point of view of the physicians who render the service and of the people who receive the service. But, and there should be no dodging of this issue, the people are going to have one plan or the other.

"If we as physicians wish to avoid state medicine, the opportunity lies immediately before us. The task that confronts us is not an easy one. Hard work and clear thinking beyond the ends of our noses are essential if we are to make the Iowa Medical Service plan a success. That it can be made a success, and a growing success, we have no doubt, for there is affirmative precedent from many states. But, the wholehearted, harmonious cooperation of every Iowa physician must be forthcoming in order to demonstrate conclusively that private enterprise can be organized to meet the demands of changing socio-economic conditions among our people. Let us not permit the forest to be obscured by the trees in our deliberation, and let us not wreck the ship at its launching."

The writer of this passage has a touch of eloquence which may seem extreme. But he says it all—whether it be 1944 or 1974. Government has made its inroads in this period of three decades. But, comparatively speaking, U. S. physicians, and Iowa physicians specifically, have a freer posture today than in most corners of the world.

The growth of Iowa Blue Shield has been most impressive over 30 years. And the liaison between founder and foundling during this period has been open and generally most satisfactory. The benefits afforded to Blue Shield subscribers and to Iowa Medical Society members far overshadow the problems which have emerged from time to time. Those of you who have served in this House of Delegates have provided the statesmanship and the steadying and settling influence which has guided the growth of Blue Shield.

It is significant that today \$80 million moves through

the conduit of Blue Shield on its way to Iowa physicians and others in reimbursement for services provided. This figure includes our regular business, as well as the Medicare, Medicaid and CHAMPUS duties we performed.

These figures speak for themselves. They reveal the major role we play in the delivery of health care in Iowa—a role which goes beyond our daily processing of claims. It goes beyond to merge with the Medical Society into a unified, cooperative and broad effort to maintain the physician as the captain of the Iowa health care team. This is our assignment as I see it, and our challenge.

As a total profession, we must identify those physicians who are willing and able to serve in capacities of leader-ship—such as yourselves—and then we must apply ourselves earnestly and ambitiously to earn and retain the confidence and support of our colleagues.

There is much work to be done. Understanding, unity, cooperation, education—these should be among our watchwords. I am pleased to have been part of the scene for a good number of years. I look forward to observing the deliberations of this House in the future. I have confidence in your ability to represent the profession.

Speaking as one who has experienced the turbulence and destruction of a tornado, I pray that the soft winds of good fortune may hover over each one of you, individually and collectively.

(Resumption of the report by Dr. Bishop)

In closing this report of the Board of Trustees, I wish to point out that the majority of us here today have been in practice for at least 10 years, and many of us for a much longer period of time. We have witnessed major and far-reaching changes in the social and economic

structure that surrounds the delivery of health care.

When we first hung up our shingles, we could devote practically all of our time and talents to treating the sick and injured who came to us for help. Our responsibilities, and the demands that are made upon us—individually and collectively—have increased tremendously, and we dare not retreat to our inner offices and busy ourselves just doing what we are trained to do. We need to maintain and reinforce our managerial role in health care delivery, and we must continue the fight to preserve the best of a free practice environment for ourselves, for the physicians who will follow us, and for our patients.

Just remember, the alternative to "organized" medicine is "disorganized" medicine. The Iowa Medical Society needs your support, and the support of all physicians in the State.

Respectfully submitted,

J. F. BISHOP, M.D., Chairman

A. J. HAVLIK, M.D.

J. H. KELLEY, M.D.

R. H. FLOCKS, M.D.

R. L. Wicks, M.D.

R. M. Chapman, M.D.

V. L. Schlaser, M.D.

T. A. BURCHAM, M.D.

At the conclusion of the Board report, Dr. Bishop presented a check for \$15,277.52 to John W. Eckstein, M.D., Dean, U. of I. College of Medicine. Dr. Eckstein acknowledged the gift, referred to items of interest to medical profession in the last Iowa General Assembly, and thanked the IMS staff for excellent service and cooperation with U. of I. College of Medicine.





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9132 Darcas Street, Omaha, Nebraska Telephane: (Area Cade 402) 393-5797
Mailing Address: Elmwaad Statian, Bax 6076, Omaha, Nebraska 68106

ASSETS:

#### INFORMATIONAL REPORT ON THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY

Presented by J. F. Bishop, M.D., President Scanlon Medical Foundation/Iowa Medical Society

The Board of Directors of the Scanlon Medical Foundation/Iowa Medical Society welcomes this opportunity to report to the 1974 House of Delegates on its activity of the past 12 months.

The gratitude of the Board is extended to those Iowa physicians who have supported the Foundation this past year. In 1973, the House of Delegates authorized a voluntary entry of \$35 on the IMS dues billing statement. This has produced \$15,570 in contributions for the Foundation. This is substantially more than has been received through previous year-end solicitation mailings. This support has been extremely vital as you will see from the balance of this report. It is the earnest hope of the Board that this participation by Iowa physicians will continue and even increase.

In 1973-74 the Foundation experienced another record year with its loan program. The number of Iowans receiving medical student loans increased over the previous year from 41 to 43. These 43 students (25 seniors, 12 juniors and 6 sophomores) received \$65,113 in loans during the period from April 1, 1973 to April 1, 1974. The amount loaned the previous 12 months was \$56,055. A listing of the medical students and their hometowns is part of this report.

The following additional statistical highlights are presented for information:

• The principal and interest received between 4/1/73 and 4/1/74 from physicians paying outstanding loans was \$11,114.07.

• The money loaned by the Foundation since the program began totals \$543,319.52.

• The loaned amount which has been repaid is \$244,942.36; the amount outstanding is \$298,377.16.

• There have been 310 loans made by the Foundation

and 162 have been repaid in full.

 Total resources on loan to the Foundation from physicians, county medical societies and specialty organizations is just under \$55,000.

Several significant contributions have been made to the Foundation during the past year which deserve recognition. Grants of \$800 have been made by the Iowa Academy of Surgery in both 1973 and 1974. A \$5,000 grant has been received from the Inter-State Postgraduate Medical Association. A \$250 contribution was made by the Prouty Company of Des Moines. A \$200 donation was made by the Black Hawk County Medical Society.

In addition, loans have been made to the Foundation by the Tama County Medical Society (\$5,000) and the Pottawattamie County Medical Society (\$1,000).

Because of its principal commitment to supporting medical education and due to the increasing limitation on available funds, the Foundation has reduced its participation in projects other than the loan program. 1973-74 support has been continued for, but limited to, the Hawkeye Science Fair, the Baldridge-Beye Scientific Lecture, the Henry Albert Monthly Scientific Presentation in the JOURNAL OF THE IOWA MEDICAL SOCIETY, and the Iowa Chapter of the Student American Medical Association.

With respect to the Henry Albert Trust, it is appropriate to note that funds accruing to the Foundation from this source amounted to \$9,731.22 in 1973. The Albert Trust, which was created in the will of the Iowa physician has provided funds for the Foundation each year since 1966.

The loan program for 1974-75 offers an uncertain outlook at this time. It most assuredly cannot be maintained at its present level unless unknown resources become available. From April 1973 to April 1974, the Foundation placed \$43,500 in new funds into the loan program account. There is now less than \$10,000 available to accommodate the loan program and other projects during the coming year. There are of course anticipated proceeds which will increase available funds, but these presumably will not be sufficient in amount to continue the loan program at its present level. In time loan repayments will increase substantially and will boost the amount of funding available for loans.

The Foundation Board of Directors will consider this matter when it meets tomorrow. It appears it will be necessary for the Board to either curtail the loan program or find additional resources to continue it at this level. It may be that the Foundation will see fit to declare a moratorium on new loans and attempt only to renew the 18 returning students (12 juniors and 6 sophomores) who are now receiving loans. This is an important and difficult task which faces the Board of Directors.

Be that as it may, let's conclude this report on an affirmative note. In just over two decades, better than 300 Iowans have been loaned over a half-million dollars to help them become physicians. The activity has increased in each of the past several years to a record level of \$65,113 loaned this current year. This is an impressive record.

#### SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY BALANCE SHEET—DECEMBER 31, 1973

Iowa State Bank & Trust Company	\$ 659.86 474.10 24,599.60 283,337.16 3,701.63	
Total Assets		\$312,772.35
LIABILITIES AND NET WORTH: Notes Payable to Physicians & County Medical Societies Note Payable to IMS Net Worth:	5,000.00	
Net Worth: Balance 1-1-73 \$246.019.21 Add: Net Gain for 1973 7,366.71	253,385.92	
Total Liabilities and Net Worth		\$312,772.35
SCANLON MEDICAL FOUNDATION/IOWA INCOME AND EXPENSE STATEMENT—I	MEDICAL DECEMBER	SOCIETY 31, 1973
INCOME: Contributions and Memorials Henry Albert Trust Interest on Loans Interest on CNB Golden Passbook Savings Special Gifts: Inter-State Postgraduate Medical	9.731.22 3.013.47	
Association The Prouty Company	5,000.00 250.00	
Total Income		\$25,339.78
Public Service Projects—		
Hawkeye Science Fair Student Tuition, Summer Workshop on	\$ 4,250.00	
Alcohol or Other Addictions  Medical Education Projects—	75.00	
Monthly Scientific Articles in IMS JOURNAL	\$ 2,000.00	
Iowa Chapter, Student AMA Baldridge-Beye Lecture	630.00	
(IMS Scientific Meeting)	668.19	
Iowa State Bank & Trust Company Interest Paid on Loans from Physicians	\$ 300.00 1,622.88	
1972 Salary Allotment	2,400.00	
Legal Services	5,000.00 843.00	
Legal Services	100.00	
Loss on Stock—Bankruptcy of American Scientific Corporation Miscellaneous Administrative Expense	60.00	
Expense	24.00	

Total Expenses .....

Net Gain for 1973 .....

\$ 17,973.07

\$ 7,366.71

TIMORE

We continue to be grateful to Lewis H. Jacques, M.D., Iowa City, for his work. He confers with each loan applicant on the student's request for assistance. Two of Dr. Jacques' loan recipients are in the House today. We would like to acknowledge the presence of John C. Rogers and Edward G. Nassif, both are juniors.

#### SCANLON MEDICAL FOUNDATION/ IOWA MEDICAL SOCIETY 1973-74 STUDENT LOAN PARTICIPANTS

STUDENT	HOMETOWN	SOPH. JR.	SR.
Barkman, Harold Jr. Bures, Frank Alan Cardwell, Dennis R. Chesney, Nelson H. Cobb, Victoria Rae	Harlan Des Moines Cedar Rapids Newell Fort Dodge		X X X X X
DeYarmen, Kent H. Evans, William Beaty Ferree, Richard A.	Cedar Rapids Davenport Panora Marion	x x	
Flory, Donald Gene Foster, Earl James Hamilton, John W. Haygood, Jerry W.	Brooklyn Clinton Bettendorf	x	X X
Herbst, John W. Kinkead, Lewis R. Kirlin, Philip C.	Cedar Rapids Cedar Rapids Waterloo Iowa Falls	x x	X
Krough, Steve Svend Kuncaitis, John J. Life, Jeffry S.	Iowa Falls	X	X X
Lowry, Michael Roy Luepke, Brian Francis McCabe, James E. McGuire, Michael Hugh Marcus, William L.	Emmetsburg Burlington Cushing Iowa City	X X X	
Maurus, Jeffrey N. Mihal, Frank Dan Miller, Edward C.	Davenport Dubuque	X	X
Munyon, Thomas G. Nassif, Edward G. Ough, James Lee Riepe, Roger E.	Des Moines Cedar Rapids Davenport	X X	X X X
Robinson, Merl Rogers, John Charles Rube, Gerald S.	Cedar Rapids Sioux City	x	X X X
Ruffcorn, Mitchell C. Schoell, John E. Schultes, Robert J. Sellers, Larry W.	Onawa Burlington Templeton Russell	X X	x
Sexton, Mark Edward Spoden, James E. Springer, Michael D.	Des Moines Guttenberg Cedar Rapids	X X	X
Thomas, David L. Thomsen, Timothy Alan Williams, James Joseph	Comanche Mt. Vernon Ottumwa		X X X

Mr. Rogers thanked members of the Iowa Medical Society for supporting the Scanlon Medical Foundation and cited examples of the Foundation's good works. He asked the delegates for their continued financial support of the Foundation and indicated this assistance to Iowa physicians-in-training could help ease the health care shortage in rural Iowa.

#### JUDICIAL COUNCIL

E. E. Gamet, M.D. Chairman, Judicial Council

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

The 1970 House of Delegates amended the IMS Articles of Incorporation and By-Laws to provide for student membership. IMS legal counsel has been working with the students at the University of Iowa College of Medicine on a constitution and by-laws which would be acceptable to the students and not be in conflict with the IMS Articles of Incorporation and By-Laws.

The Judicial Council has reviewed the student constitution and by-laws and finds them to be in order, and has recommended approval. The Judicial Council, therefore, recommends that the House of Delegates issue a charter to the Student Iowa Medical Society as a component society of the Iowa Medical Society.

An informational copy of the Student Iowa Medical Society Constitution and By-Laws is below.

### CONSTITUTION OF THE STUDENT IOWA MEDICAL SOCIETY

#### ARTICLE I. NAME

The name of the organization shall be the Student Iowa Medical Society.

#### ARTICLE II. OBJECTIVES

The objectives of the Society shall be:

To be committed to the improvement of health care and health care delivery to all people; to promote the active improvement of medical education; to involve its members in the social, moral and ethical obligations of the profession of medicine; to assist in the improvement and understanding of world health problems; to contribute to the welfare of medical students, interns, residents, and post-M.D. trainees; to advance the profession of medicine.

In furtherance of these purposes, this Society shall cooperate closely with the University of Iowa Chapter of the Student American Medical Association and, to the extent feasible, shall meet jointly with that organization while recognizing that some members of that organization may not wish, or would not be eligible, to join the Society.

#### ARTICLE III. MEMBERSHIP

Membership in the Society shall be open to students in good standing at the Medical School of the University of Iowa. The qualifications, rights, obligations and method of admission shall be set forth by the By-Laws.

#### ARTICLE IV. AMENDMENTS OF THE CONSTITUTION

This Constitution may be amended, but only after review of the proposed amendment by the Executive Council, following which the proposed amendments shall be submitted to the membership, with or without recommendation of the Executive Committee. The proposed amendments shall be voted upon by the members of the Society at any meeting, but only after they shall have been submitted in writing to each member of the Society by mail at least thirty (30) days prior to such meeting. The affirmative vote of a majority of the members present and voting on such amendment shall be required for adoption of a proposed amendment.

#### BY-LAWS OF STUDENT IOWA MEDICAL SOCIETY

#### ARTICLE I. MEMBERSHIP

Membership in the Society shall be available to students in good standing at the Medical School of the University of Iowa who have paid the required dues of the Society. The Society shall hold meetings of the members at such times as are designated by the Executive Council. Notice of a meeting shall be given at least one (1) day prior thereto by posted notice.

#### ARTICLE II, OFFICES

Section 1. The officers shall be the President, Vice President, Secretary, and Treasurer. The President, Vice President, Secretary, and Treasurer shall be elected by all members in attendance at a meeting in April. Nominations for these positions shall be made at the preceding March meeting. Any member of the Student Iowa Medical Society shall be eligible to run for office.

Section 2. The President shall preside over all meetings. He shall appoint committees except those whose methods of selection are specified in their organizational motion. He shall determine duties of the Officers and Class Repre-

sentatives in addition to those specified in the By-Laws. Section 3. The Vice President shall assume the duties of the President at such times when the President is unable to perform them.

Section 4. The Secretary shall keep the minutes of all meetings and be responsible for all official correspondence.

Section 5. The Treasurer shall be responsible for all monies and records thereof.

#### ARTICLE III. CLASS REPRESENTATION AND PUBLICATIONS EDITOR

Each yearly class at the Medical School shall have one class representative. Any member of the Society who is not an officer shall be eligible for election as a class representative. Class representatives shall be appointed by all members of the Executive Council at any time as soon as feasible after the election of officers. The Publications Editor shall be elected each year by the newly elected Executive Council at the first council meeting after election of officers.

#### ARTICLE IV. EXECUTIVE COUNCIL

Section 1. The Executive Council shall consist of the Officers, Class Representatives, Publications Editor, and Chairmen of Standing Committees.

Section 2. The Executive Council shall have the power to determine all policy of the Student Iowa Medical Society, except as specified in the constitution.

Section 3. A quorum shall be 50 percent of the membership of the Executive Council. All actions, except amendment of the By-Laws, shall require a vote of the majority of those present and voting to pass.

Section 4. Executive Council meetings shall be held at the discretion of the officers. Any member may attend and be recognized, but only Executive Council members shall vote on business. Executive Council meetings and General Business meetings may be held concurrently.

#### ARTICLE V. IOWA MEDICAL SOCIETY

Section 1. The Society shall seek to receive a charter from and become a component part of the Iowa Medical Society. The Society shall not alter or amend its Constitution or By-Laws in any way that would conflict with the Articles of Incorporation and By-Laws of the Iowa Medical Society, and any such alteration or amendment held by the Judicial Council of the Iowa Medical Society to be so in conflict shall be null and void.

Section 2. A sufficient number of delegates and alternates to accord with the Articles of Incorporation and By-Laws of the Iowa Medical Society shall be elected in each year by all members in attendance at a meeting in April. Nominations for these positions may be made at the preceding March meeting. All student members in good standing of the Iowa Medical Society shall be eligible for election as delegates and alternates.

#### ARTICLE VI. FINANCES

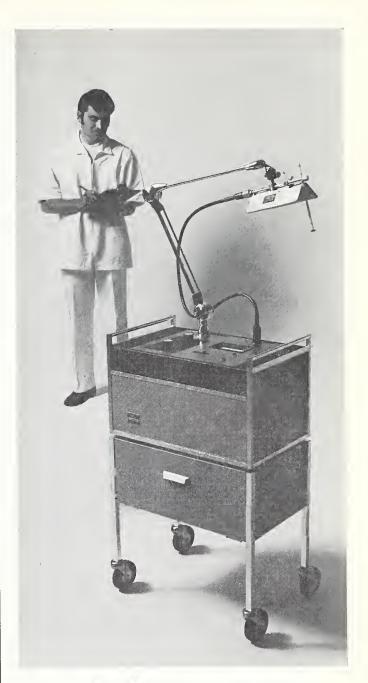
Section 1. Dues for members of the Society shall be fixed by the Executive Council. The Treasurer shall collect dues.

Section 2. No funds may be raised for activities and publications of the Society from sources disapproved by the Executive Committee.

Section 3. Funds may only be expended by order of the Executive Committee on checks signed by the Treasurer or his appointee to defray expenses of the Society, its publications, and to further the purposes of the Society.

#### ARTICLE VII. COMMITTEES

There shall be such committees as may from time to time be created by the Executive Committee. The duties



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of such committees shall be designated by the Executive Council and they shall operate under the supervision of the Executive Council, and report to the Executive Council

#### ARTICLE VIII. PARLIMENTARY AUTHORITY

The rules contained within Robert's Rules of Order Revised (latest edition) shall govern this Society in all cases to which they are applicable, and in which they are not inconsistent with the Constitution or these By-Laws or the special rules of order of this Society.

#### ARTICLE IX, AMENDMENTS TO THE BY-LAWS

Proposed amendments to these By-Laws shall be considered at any meeting of the Executive Council. Any member of the Society may propose amendments to these By-Laws by submitting such proposals in writing to the President at least ten (10) days prior to the meeting of the Executive Council at which they are to be considered, and the President shall promptly furnish a copy of the proposed amendment to all members of the Executive

Council. An affirmative vote of at least a majority of the Executive Council members present and voting shall be necessary for the adoption of any such proposed amendments. In addition, any member of the Executive Council may propose amendments to these By-Laws without prior notice, except that in such cases, an affirmative vote of at least two-thirds (%) of the Executive Council members present and voting shall be necessary for the adoption of any such proposed amendments.

Respectfully submitted,
E. E. GAMET, M.D., Chairman
C. L. KELLY, JR., M.D.
H. G. MARINOS, M.D.
D. F. RODAWIG, JR., M.D.
D. M. YOUNGBLADE, M.D.
C. H. DENSER, JR., M.D.
A. M. DOLAN, M.D.
J. E. TYRRELL, M.D.
J. F. COLLINS, M.D.
K. A. GARBER, M.D.
H. RASSEKH, M.D.
E. E. LINDER, M.D.

### Supplemental Reports of Standing Committees

#### NECROLOGY COMMITTEE

(The Speaker asked the members of the House of Delegates to stand while E. E. Gamet, M.D., Chairman of the Judicial Council, read the names of IMS members who died in 1973. The list appears on page 282 of this issue of the JOURNAL.)

#### NOMINATING COMMITTEE

The Nominating Committee of the Iowa Medical Society met on Sunday, March 31, 1974 and agreed upon the following slate to be presented to the House of Delegates today.

President-Elect Vice President Verne L. Schlaser, M.D., Des Moines Thomas E. Kiernan, M.D., Newton Mark D. Pabst, M.D., Bloomfield

Speaker of the House of Delegates

Lynn D. Caraway, M.D., Amana

Vice Speaker of the House of Delegates

Robert D. Whinery, M.D., Iowa City Anthony S. Owca, M.D., Centerville

Trustee (3 year term)

John H. Kelley, M.D., Des Moines Keith A. Garber, M.D., Corydon

Trustee—to complete unexpired term (Term expires 1975)

James F. Bishop, M.D., Davenport

Delegate to AMA (2 year term) (Two to be elected)

John R. Anderson, M.D., Boone Lynn D. Caraway, M.D., Amana (name withdrawn) Erling Larson, Jr., M.D., Davenport John M. Rhodes, Sr., M.D., Pocahontas John R. Scheibe, M.D., Bloomfield Leslie W. Swanson, M.D., Mason City

Councilor, 2nd District (3 year term)

Warren V. Wulfkuhler, M.D., Mason City

Councilor, 3rd District
—to complete an unexpired term (1975)

Donald F. Rodawig, Jr., M.D., Spirit Lake

Councilor, 7th District (3 year term) Councilor, 8th District

John E. Tyrrell, M.D., Manchester

(3 year term)
Councilor, 9th District

Robert L. Kent, M.D., Fort Madison

(3 year term) Councilor, 12th District Sidney A. Smith, M.D., Oskaloosa

Councilor, 12th District (3 year term) Enfred E. Linder, M.D., Ogden

Blue Shield Liaison Delegate to IMS (Two to be elected)

Edwin A. Motto, M.D., Davenport John R. Scheibe, M.D., Bloomfield Cecil W. Seibert, M.D., Waterloo Jackson D. Ver Steeg, M.D., Des Moines

Additional nominations may be accepted from the floor after which the Speaker of the House of Delegates will declare nominations closed.

The Articles of Incorporation and By-Laws require that for candidates to be unopposed for nomination they must be unanimously approved by the Nominating Committee. Although it is recognized that it is desirable to have two candidates as a minimum for each of the proposed offices, the Nominating Committee is submitting but one candidate for some offices since these were the only names formally proposed to the Nominating Committee and were unanimously approved by the Nominating Committee.

It will be noted that there are four candidates for the two offices of Blue Shield Liaison Delegate to the Iowa Medical Society. Under the Articles of Incorporation and By-Laws of the Iowa Medical Society, the Liaison Committee shall submit to the Nominating Committee the names of four or more candidates for the two positions of Liaison Delegate. Therefore, under the IMS By-Laws, it is mandatory that four or more names be submitted to the Nominating Committee for these offices. These names are merely received by the Nominating Committee and submitted as a part of its report to the House of Delegates.

The meeting was adjourned at 3:30 p.m.

Respectfully submitted,
J. L. Garred, M.D., Chairman
J. C. Carr, M.D.
T. C. Graham, M.D.
K. Hahn, M.D.
C. P. Hawkins, M.D.
C. Jons, M.D.

K. J. Judiesch, M.D. J. D. Kimball, M.D. T. J. Payne, M.D.

S. A. SMITH, M.D. D. J. WALTER, M.D.

R. L. ZOUTENDAM, M.D.

Nominations from the floor were requested, but none were presented. The report of the Nominating Committee was adopted as presented.

# COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

(Referred to Reference Committee on Articles of Incorporation and By-Laws.)

The IMS Board of Trustees in its supplemental report is recommending to the House of Delegates that physicians in their first two years of practice be permitted to join the IMS by paying one-half the current dues. Legal counsel has drafted appropriate language to implement this recommendation if adopted by the House.

In keeping with the Articles of Incorporation and By-Laws, the proposed amendment has been reviewed by the Committee and found to be in order. The proposed amendment is set forth below for referral to the appropriate Reference Committee which is considering the recommendation from the Board of Trustees.

Resolved, That Article 7, Section 1, be amended to read as follows:

"Funds for meeting the expenses of this Society shall be raised by annual per capita dues and may also be raised by special dues upon each component society, which dues shall be fixed by the House of Delegates. Nothing in these Articles or in the By-Laws shall predude the House of Delegates, the House having first heard the recommendation of the Board of Trustees thereon, from fixing the dues for student members on other than an annual basis or from fixing the dues for student members, interns, residents or active members in their first two years of active practice, at an amount less than the regular dues. Funds may also be raised by voluntary contributions, from the Society's publications, or in any other manner approved by the House of Delegates."

Respectfully submitted,
K. J. Judiesch, M.D., Chairman
J. F. Bishop, M.D.
R. J. Dawson, M.D.
P. J. Leehey, M.D.
C. R. Rominger, M.D.
H. J. Smith, M.D.

#### COMMITTEE ON LEGISLATION

The supplemental report of the Committee on Legislation was presented by Dr. D. C. Young, Chairman, for delegates' information only. Dr. Young summarized the five legislative measures given IMS priority status: bills (1) to expand chiropractic, (2) to alter the confidentiality of patient records, (3) to modify drug anti-substitution laws, (4) to add lay people to licensing boards, and (5) to require insurance coverage for chiropractic and optometric services.

Dr. Young reported the following outcomes: (1) chiropractic measure was amended and passed despite opposition from the IMS and others (including a special State Chiropractic Study Committee); the act enables chiropractors to adjust the entire musculoskeletal structure and use other incidental procedures limited to heat, cold, exercise and supports; it also prohibits chiropractic advertising; (2) the bill to ease attorney access to patient records was shelved; (3) the bill to modify drug antisubstitution laws was killed; (4) the composition of the Board of Medical Examiners was changed to 5 MD's, 2 DO's and 2 lay people; and (5) the bill to expand insurance coverage for chiropractic and optometric services was held in committee.

Dr. Young noted four other bills which received Society attention: one which granted drug prescribing authority to podiatrists; another expanded authority of the

Board of Medical Examiners; a third requiring physicians to write prescriptions for drug samples was held in committee; and finally, a Society sponsored measure allowing bodies to cross state lines for autopsy purposes was enacted.

Dr. Young predicted increased legislative activity by other of the health professionals in the upcoming session. He said efforts will be made by the IMS to encourage discussion between the several groups.

In concluding his remarks, Dr. Young indicated the new legislative priority system was successful, 9 of 12 bills were handled in accordance with IMS desires, one ended in a reasonable compromise and two were lost. He cited generally favorable reactions from legislators. He urged all Society members to become acquainted with legislators and to offer assistance on medically related issues.

Next, Dr. Young introduced Dr. Erling Larson, Jr., retiring chairman of the Iowa Medical Political Action Committee. Dr. Larson commented briefly on the growth of IMPAC and introduced his successor, Dr. Robert Whinery. Following his acceptance of the position, Dr. Whinery presented Dr. Larson with a trophy for his outstanding leadership and service to IMPAC from 1971-1974. Dr. Whinery then asked the delegates for their continued support of IMPAC and told of the necessity for political participation by the medical profession. He urged the delegates to work for local candidates and to become acquainted with their legislators.

#### MEDICO-LEGAL COMMITTEE

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

The Medico-Legal Committee met March 21, 1974 with the Insurance Commissioner and others interested in professional liability insurance coverage for Iowa physicians. This supplemental report will provide members of the House of Delegates with information presented at the March 21 meeting.

Insurance Commissioner William Huff advised the Committee that premium increases have been filed recently by all principal insurance companies writing professional liability coverage in Iowa. The Insurance Service Office (ISO) requested an approximate 50% increase for the companies it represents: St. Paul, INA, USF&G and Travelers. The Aetna has filed an overall rate increase of 64%. The Medical Protective has asked for a premium hike of about 50% in the lower classifications and 20% in the higher ones. These increases have now been approved. They are reported to be the first since early to mid 1972; governmental rulings have held premiums essentially in check during this period.

According to Commissioner Huff, the companies present a complex loss picture to justify their rate requests. He acknowledges that evaluation of actual Iowa experience is difficult to make. He has explained the efforts of his department in this regard and has offered to assist the Society in securing additional information.

Iowa law allows an aggrieved party to request a hearing on any rate increase. The Committee has considered this possibility and has rejected it at this time. The belief exists that the result would not be commensurate with the investment in the services of a consulting casualty actuary. The process of rate making has been found to be extremely complex and it varies considerably.

The Committee regrets having to report these rate increases. But it does find solace in the fact that several companies remain active in the Iowa market. Consequently, Iowa physicians appear to have some competitive op-

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tions available. Other states have been less fortunate, e.g., in New York the announced withdrawal of Employers of Wasau has created serious problems; in Florida a dismal report has been issued on the experience of the new FMA program.

In addition to discussing the rate increase, Commissioner Huff touched on the following matters at the March 21 meeting: (1) Utilization of the no-fault concept in professional liability appears to be remote; (2) The broad concept of arbitration seems to be receiving increased attention. Noteworthy is the California program where patients sign an agreement to submit any grievance to arbitration. Early results of this experimental program seem encouraging. (The Committee has concurred that discussions on this subject with representatives of the Iowa State Bar Association seem justified. Commissioner Huff has volunteered to assist in arranging such a meeting.) (3) An earlier problem of coverage for osteopathic physicians and surgeons associated with medical doctors seems to have been resolved; (4) The Iowa Code permits an association to establish and operate its own liability insurance company and buy reinsurance as necessary. According to Mr. Huff, this provision has never been used; (5) The current Iowa situation, while disconcerting from the cost standpoint, is moderately healthy from a comparative standpoint.

The 75th anniversary activities of the Medical Protective Company were reported by Mr. Roger Garner. He noted the company's increase in coverage limits to one million dollars. Mr. Garner defended his company's open market philosophy and assured the Committee Medical Protective has no plans to withdraw from Iowa.

The Committee also conferred with Mr. John Reno of The Prouty Company. The Prouty Company serves as the Society's group insurance administrator. In that capacity, Mr. Reno and his associates have contacted several companies to discuss possible Society-sponsored professional liability programs. Contacts were made in 1973 with Hartford, Travelers, Aetna and INA. The general response from these companies has been one of interest but all stopped short of wanting to propose a group coverage in Iowa at this time. Market penetration by Medical Protective was cited as a main deterrent to any strong interest by the other companies.

The good relations established with these several companies deserve to be fostered in the event a change in the coverage situation becomes necessary. Mr. Reno was encouraged to maintain his contacts and consider additional ones.

The following two summary points are offered by the Committee:

- (1) The announced and approved premium increases for professional liability coverage in Iowa are distressing, but the situation is apparently still more favorable than in most parts of the country.
- (2) The open market which exists in Iowa has some virtue in that it fosters the elements of competition and selection.

The Committee expects to continue its study of professional liability in the ensuing year. Specifically, it expects to do the following unless the House of Delegates indicates otherwise:

- (1) Conduct a survey of state medical associations to secure an accurate reading on the status and types of coverages available elsewhere. A survey form has been prepared.
- (2) Seek a conference with representatives of the Iowa State Bar Association on the feasibility of the arbitration or screening panel system. The assistance of Commissioner Huff will be sought with this project.
  - (3) Maintain ongoing contact with those companies

now writing individual professional liability coverage in Iowa in an effort to demonstrate the profession's desire to maintain surveillance over developments and offer medical expertise as possible.

Respectfully submitted,

C. H. DENSER, JR., M.D., Chairman

G. H. Ashline, M.D.

K. K. HAZLET, M.D.

J. H. KELLEY, M.D.

W. H. KRIGSTEN, M.D.

R. P. LAGONI, M.D. R. D. ROWLEY, M.D.

E. D. THOMPSON, M.D.

J. M. TIERNEY, M.D.

W. V. WULFEKUHLER, M.D.

# SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

The subject of communicable disease has received priority attention from the Iowa Medical Society Subcommittee on Maternal and Child Health for a number of years. The ongoing consideration of this important topic has frequently involved officials of the State Department of Health.

Several actions of the House of Delegates have emanated from these previous deliberations of the Subcommittee. For example, the 1967 House of Delegates endorsed an SDH Statement of Policy Concerning Circumstances of Immunization Administration. And last year, again on the Subcommittee's recommendation, the IMS Executive Council approved a statement noting the re-appearance of rubeola in Iowa and calling for use as needed of the Rapid Response to Measles Program of the State Department of Health.

In recent days the Subcommittee has considered a further statement devised by the SDH concerning communicable disease. The statement has been reviewed by the Subcommittee and has been found acceptable with minor modification. The statement is submitted to the House of Delegates with the request that it be endorsed and that the Subcommittee be authorized to work with the SDH in its implementation.

### DISEASE ERADICATION PROGRAM IOWA STATE DEPARTMENT OF HEALTH

Only 10 cases of rubeola and 10 cases of rubella were reported to the State Department of Health in the first four months of 1974. These dramatically low figures compare with 1,114 cases of rubeola reported in 1972 and with the several thousand cases of both rubeola and rubella recorded 10 years ago. These statistics are enhanced even more by the fact that the current surveillance and reporting system is much improved.

Findings such as these suggest that past cooperative efforts of the Iowa State Department of Health and the Iowa Medical Society are paying dividends. It appears now the stage has been set for a statewide eradication of the "immunizable" diseases (with the exception of mumps).

The following subjects are relevant in this discussion and will be of consequence in any cooperative drive to eradicate totally the prevalent childhood diseases of rubeola and rubella.

#### The Climate for Eradication

Important elements in a broad eradication effort include: (1) a small enough susceptible population to sug-

gest limited opportunity for disease spread; (2) an adequate surveillance system; (3) a set of procedures to assure and/or confirm diagnosis; (4) adequate personnel and facilities to provide epidemiology to surround any confirmed case; and (5) a concerted professional and public education program to stimulate early and adequate immunization with total eradication the end goal.

This additional background information is pertinent in the consideration of a full scale Iowa eradication effort:

1) Over 500,000 doses of rubella vaccine were administered to pre-pubertal children in 1970; over 100,000 doses of measles and measles/rubella combined vaccines have been administered in public programs the past two years; all major distributors of vaccines indicate increased utilization of their products by the private sector; statewide surveys of parents of pre-school and kindergarten children reflect a 75-90% immune status of these children.

2) Nursing personnel in 90 Iowa counties now provide weekly communicable disease reports to the State Department of Health; disease reporting from private physicians, day care centers, Headstart programs, etc., has increased

over the past two years.

3) Since July 1973, every reported case of rubeola or rubella has been investigated by a qualified representative of the State Department of Health. Parents of children with suspected rubella or rubeola have been urged to see their doctor; minimum symptom information has been obtained where possible; and the State Hygienic Laboratory has provided complement fixation studies for rubeola titer and hemagluttination inhibition titering for suspect rubella specimens.

4) School nurses, county public health nurses and immunization specialists have been trained in many phases of practice epidemiology. Many have received a Standing Order of Procedure to follow in a confirmed case of com-

municable disease.

5) There is reason to believe the U. S. Public Health Service, several vaccine manufacturers, the Iowa Pharmaceutical Association and others are ready to assist in a concerted *health education* effort to eradicate communicable disease.

#### The Potential Role of the Iowa Medical Society

Through its efforts, those of its component county societies and its individual members, the Iowa Medical Society has already contributed substantially to the eradication of these diseases. Through its Subcommittee on Maternal and Child Health, the Society has maintained open lines of communication with the State Department of Health. Significant support was given by individual physician members and components of the Society during the 1972-73 school year to thwart the resurgence of rubeola. In 1973, the Society's president-elect and other IMS physicians participated in an educational program during the October Immunization Action Month.

In this proposal to make Iowa the "First State to Eradicate," three principal measures will require the endorsement of and support from the Society and its af-

filiated county societies:

1) Physicians in private practice must voluntarily and conscientiously report cases of these diseases to the State Department of Health (a toll-free telephone line is being considered for this purpose).

2) Physician cooperation and assistance will be needed to help school nurses and local health department personnel confirm any suspected case through appropriate

clinical or laboratory methods.

3) The Society may need to encourage local medical approval of (and enlist medical supervision for) limited public immunization clinics which may be necessary in order to surround a case. It is hoped this activity will

eliminate any county-wide or state-wide immunization campaigns, except where this approach is desired by county or community representatives.

#### The Role of the State Health Department

It will be the responsibility of the State Department of Health to have qualified support personnel available to assist in local areas with required epidemiology. The Department additionally will step up efforts to motivate the parents to get their infants to family physicians for adequate immunization on a routine basis. The routine booster immunization of children at school entry will be encouraged to prevent the build-up of the susceptible population.

#### Summary

The immunizable communicable diseases of diphtheria, pertussis, tetanus, polio and small pox, for all practical purposes, have been eliminated in Iowa. Now, the total eradication of rubella and rubeola in Iowa appears to be a definite possibility. Favorable statistical data available at this time provide a stimulus for seeking this goal. It is believed this would be the first effort of this proportion in the United States. Iowa has demographic and other features which make the goal realistic-not the least of which is a relatively well-educated, affluent and concerned citizenry. The combined efforts of the Iowa Medical Society and the Iowa State Department of Health are imperative if any concerted public and professional education program is to be undertaken. With direction from these two organizations and support from other agencies, it is quite possible that Iowa may become the "First State to Eradicate."

Respectfully submitted,
G. L. Baker, M.D., Chairman
W. J. Balzer, M.D.
D. D. Faber, M.D.
CHARLOTTE FISK, M.D.
J. L. Kehoe, M.D.
D. O. Newland, M.D.
ELIZABETH D. PROCTER, M.D.
C. W. SEIBERT, M.D.
C. W. STEVENS, M.D.
J. M. Wall, M.D.
J. J. Weyer, M.D.

### Supplemental Reports of Special Committees

# COMMITTEE ON DELIVERY OF HEALTH SERVICES

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

In response to a directive from the 1973 House of Delegates, the Committee on Delivery of Health Services has given study and consideration to the following resolution submitted to the House of Delegates last April by the Dallas-Guthrie County Medical Society:

"Whereas, We as practicing physicians in rural Iowa are concerned about adequate and continuous medical care for the people in the rural areas of Iowa; and

"Whereas, Satellite units are being set up from metropolitan medical centers as 'Rural Medical Family Practice Units' on an office hours-office practice type of service in rural areas, and

"Whereas, These services do not include 24-hour, sevendays-a-week care for the people they are purportedly serving; and "Whereas, Medical family practice includes continuous care, both as far as the continuous and whole care of the patient is concerned, and in continuous coverage during the day and night; therefore be it

"Resolved, That 'Rural Medical Family Practice Units' be required to be manned by physicians 24 hours per day, so that adequate, continuous medical care may be rendered to the people in the rural areas, and near-by physicians will not be asked to see these patients after

normal daytime office hours."

The Committee has met with representatives of the Dallas-Guthrie County Medical Society, and with the professional corporation in Des Moines which operates the emergency room department at Iowa Methodist Hospital, as well as the satellite medical clinics located in Baxter, Granger and Panora. These satellite medical clinics utilize the services of physician's assistants. Based on the discussion with, and the information provided by these representatives, the Committee submits the following comments and recommendations for action by this House of Delegates:

The Committee is in sympathy with the resolution of the Dallas-Guthrie County Medical Society and, like the county society, is also interested in assuring the provision of continuous medical care to all citizens of the state; however, the Committee acknowledges that daily 24-hour coverage by an M.D. is not always possible, as many solo

practitioners in the state will attest.

The Committee is pleased to point out that in conferring with representatives of the D-G county medical society and the professional corporation that operates the satellite medical clinics in the area, there appears to be a mutual understanding and appreciation of each other's situation and views. It is the opinion of the Committee that there is no serious polarization, and any problems can probably be resolved without the establishment of rigid restrictions, endorsed by the IMS, pertaining to the operation of satellite clinics.

The Committee also wishes to note that the State Board of Medical Examiners, as well as representatives of the IMS, are in the process of evaluating the function and responsibilities of the physician's assistant, and any final rules and regulations established by the BME should provide strong guidelines under which satellite medical clinics operate and physician's assistants function.

In light of the above comments and observations, the Committee recommends:

1) that Resolution #4 of the Dallas-Guthrie County Medical Society not be adopted;

2) that officials of the county medical society and the professional corporation in charge of the satellite medical clinics be encouraged to confer as necessary to discuss any areas of disagreement in an effort to clarify misunderstandings and to resolve existing problems in a mutually satisfactory manner at the local level; and

3) that the IMS Committee on Delivery of Health Services and the State Board of Medical Examiners be called upon, when necessary, to offer their guidance and counsel.

The Committee has also given attention to activities currently taking place in the field of nursing, especially those dealing with programs designed to extend the role of the nurse in patient care. It is pleased to note that the Society's Committee on Delegation of Authority plans to arrange a meeting with representatives of the Iowa Nurses' Association, the Board of Nursing Examiners, the Board of Medical Examiners, and the Board of Health to discuss the broad subject of the expanded role of the nurse and what is being considered with respect to specific programs and/or legislation. In light of these developments, the Committee submits the following recommendation for action by the House:

That the Iowa Medical Society, through appropriate officers and committees, continue to be alert to the various activities, studies, and philosophies related to the functions and responsibilities of the nurse, as well as the physician's assistant, in patient care, so that the medical profession can remain active in providing guidance and leadership as to the future roles of these two important ancillary professions to medicine.

Respectfully submitted,
M. E. Olsen, M.D., Chairman
M. E. Kraushaar, M.D.
P. J. Leehey, M.D.
J. K. MacGregor, M.D.
D. F. Rodawig, Jr., M.D.
J. W. White, M.D.
K. E. Wilcox, M.D.

#### COMMITTEE ON DRUG ABUSE

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

The Committee on Drug Abuse of the Iowa Medical Society has had meetings with Mr. Fred Brinkley, Director of the Iowa State Drug Abuse Authority, and recently conferred with Phil Levine, Ph.D., former Director of the IDAA, and a Professor of Pharmacology at Drake University, Des Moines.

In meetings with Mr. Brinkley, he has pointed to the abuse of prescription drugs as a problem of such significance that it warrants special attention by the medical profession, and he has offered the opinion that it is likely additional restrictions will be imposed on the use of prescription drugs via federal rules and regulations if nothing is done to alleviate alleged problems of abuse and misuse. In this connection, some preliminary studies are being used by politicians to suggest that irrational and careless prescribing practices by physicians are a routine occurrence.

During the Committee's session with Dr. Levine, there was mutual agreement that in order to assess the imagined or real problems related to the abuse and misuse of licit drugs, and to obtain pertinent information regarding the prescribing habits of physicians, it would be beneficial to conduct a fact-finding study to determine, among other things, the drugs that are most frequently

prescribed, and why.

Dr. Levine has indicated that such a study could be developed using a random sample group of physicians, whose anonymity would be totally preserved; further, that the results of such a study would become the property of the IMS, and could be used to determine educational needs of physicians, so that appropriate educational programs could be implemented to alleviate problem areas.

The Committee is of the opinion that in order (a) to be able to refute with objective data the allegations which have been made at the national, state and local levels; (b) to be better able to make rational recommendations to the IMS regarding any proposed changes in regulations that apply to the use of prescription drugs; and (c) to help define any educational needs of Iowa physicians in pharmacotherapeutics, it would be desirable and would serve the best interest of the IMS, its members and their patients, to collect pertinent information regarding the drug prescribing practices of physicians; therefore, the Committee on Drug Abuse recommends that the House of Delegates authorize it to investigate the actual cost, the possible funding mechanisms, and the mechanics of implementing such a study, with the understanding that the results of the study would become the property of the IMS and the total anonymity of participating physicians (and their patients) would be preserved; further, that the results of such an investigation by the committee be presented to the IMS Executive Council at a future meeting so that it can either approve or disapprove implementation of the proposed project.

Respectfully submitted,

F. W. Bennett, M.D., Chairman

J. A. Bullard, M.D.

O. N. GLESNE, M.D.

D. A. HARDING, M.D.

R. W. OVERTON, M.D. C. E. RADCLIFFE, M.D.

Hormoz Rassekh, M.D.

K. H. STRONG, M.D.

#### COMMITTEE ON EYE CARE

(Referred to Reference Committee on Legislation and Medical Service.)

Because of activity at the federal level and increased mention in labor management negotiation, some rather strong interest is being demonstrated in vision care programs by Iowa groups due to more public and private eye-care education and awareness that several other states have existing programs.

The scope of existing programs generally include, but is not necessarily limited to: eye examinations or vision survey and analyses, refractions, prescription lenses and frames. Frequency of coverage of these services and items varies.

In some states, the services and items are provided only by optometrists; in others, by a combination of ophthalmologists, optical laboratories and optometrists.

Your Committee met twice with Blue Cross/Blue Shield representatives to discuss the possibilities for such a program in Iowa. Further, the Committee distributed a questionnaire to all Iowa ophthalmologists to determine their evaluation of the need for a prepaid vision program in the state. Approximately 70 questionnaires were distributed and 46 have been returned. There were 34 respondents who disapproved of any efforts to establish a prepaid program and 12 respondents who approved of such a program.

In view of this expression, the Committee on Eye Care does not plan to pursue any formal proposal relative to prepaid eye care, until or unless circumstances change as expressed by Iowa ophthalmologists.

Respectfully submitted,

A. H. DOWNING, M.D., Chairman

M. E. COLLENTINE, M.D.

J. B. Dixon, M.D.

R. H. Foss, M.D.

B. M. Merkel, M.D.

E. M. SWANSON, M.D.

R. H. Watt, M.D.

A. C. WISE, M.D. F. C. BLODI, M.D.

# COMMITTEE ON HEALTH CARE IN CORRECTIONAL INSTITUTIONS

(Referred to Reference Committee on Reports of Offi-

cers and Miscellaneous Business.)

A study of health care in Iowa correctional facilities was urged by the Dubuque County Medical Society in a resolution submitted to the 1973 Iowa Medical Society House of Delegates. The House of Delegates sustained the Dubuque County resolution by approving the following language:

"Resolved, That the President of the Iowa Medical Society appoint a special committee to investigate the quality of medical care at the correctional institutions in the

State of Iowa and make any appropriate recommendations to the House that might be indicated by its findings."

This action led to the appointment by the Society President of a Committee on Health Care in Correctional Institutions.

Of significance at the outset of this report is the fact that the American Medical Association and the American Bar Association have cooperative efforts underway at the national level to "institute and improve the medical and health services in the nation's jails and prisons." This joint effort may lead to a program of certification wherein a state or county medical society will evaluate a facility and conclude (or not conclude) that the medical services do meet acceptable standards.

In its initial deliberations, because of the potentially extensive nature of the project, the Committee on Health Care in Correctional Institutions decided to restrict its investigation and evaluation to the four state-supported facilities. In the 1973-74 Society year, the Committee (1) has met on three occasions at IMS Headquarters, (2) has requested and studied reference materials in this field, (3) has conducted a written survey (a summary of the survey accompanies this report), (4) has made field trips to the four state correctional institutions, and (5) based on the preceding, has compiled this report.

The four state-operated correctional institutions are the Iowa Men's Reformatory, Anamosa; the Iowa State Penitentiary, Ft. Madison; the Iowa Women's Reformatory, Rockwell City, and the Iowa Security Medical Facility, Oakdale.

The Committee is pleased to acknowledge the excellent cooperation and support offered by Mr. Nolan Ellandson, Director, Bureau of Corrections, State Department of Social Services. Similar assistance was provided by the officials of the four correctional institutions.

In addition to the previously-noted fact-finding activities, the Committee also has used data from an interrogatory and resulting institutional replies ordered by the Court. In their visitations to the four state institutions, Committee members (1) discussed the provision of medical services with administrative staff, (2) conferred with residents (inmates) on medical services available to them, (3) inspected those physical facilities designated as health or medical service areas, and (4) drew on these experiences to prepare this report.

One conclusion is readily apparent to the Committee after these recent experiences: Except for the Iowa Security Medical Facility, full-time professional medical staff is difficult to obtain and retain. There are various reasons for this:

(1) The reimbursement provided in the past to physicians serving in a full-time capacity has not been commensurate with the earnings of a private practitioner.

(2) The confines of a correctional institution do not, in most instances, provide an atmosphere of challenge to a medical practitioner. In the correctional institution setting, the patient population is restricted in selection and freedom of choice for patient and doctor is restricted.

(3) The opportunity for association with professional colleagues is limited for the full-time institutional physician.

(4) The limited nature of the practice is considered a deterrent to the employment of a full-time physician. In the main, the inmate population is physically healthy and does not require extensive coverage, except in the areas of preventive and trauma care.

#### Assessment of Present Institutional Medical Services

Medical services at three of the four correctional facilities are now provided essentially on a contract basis. The exception to this is the Oakdale facility. The contracts at Anamosa, Fort Madison and Rockwell City are either with local or nearby physicians and/or residents from the University of Iowa College of Medicine.

Each institution has available an infirmary type hospital which is adequate for minor illnesses or the recovery portion of more serious disabilities. These are staffed at least on a part-time basis by nursing personnel, who assist with sick call, drug dispensing, etc.

Psychiatric care is available on a part-time basis in Anamosa, Fort Madison and Rockwell City, and full-time at Oakdale. Psychologists are available at all facilities.

Hospitalization for more serious conditions is available

at Oakdale in the University environs. Anamosa and Fort Madison send cases of a serious nature to University Hospitals. Rockwell City utilizes the Lake City hospital (14 miles distant) and also University Hospitals. Emergencies are attended to by local doctors in community hospitals when the need arises, which is infrequent. The referral of cases to consultants and specialists at the University of Iowa is handled with expedience, perhaps even more speedily than for the general public or indigent patients.

Pharmaceuticals are available at all institutions in proper amounts and with reasonable safeguards. Oakdale

### SUMMARY OF HEALTH CARE SERVICES IN IOWA CORRECTIONAL INSTITUTIONS

Accorage Number of Image   Mapper of Image   M	Institution	Fort Madison	Anamosa	Oakdale	Rockwell City	Institution	Fort Madison	Anamosa	Oakdale	Rockwell City
Part	Total Capacity	900	600	81		Manner of Physician				
Available Medical Facilities:   Secretary   Facilities:   Secretary						Fee-for-service-		v		
Houte Wase   Name   N	Available Medical	600	521	78		per patient		(Emer-		x
Semining Room		x	x	X	x	Hourly Wage	X			
Part						Salary			X	
Facilities For:   Acute Care   X	Clinic/Dispensary	X	X	X	X	Other				
Mentally III		x	x					Daily		
Drug Addicts		X	(TB, Dia-		X	with Physician to Provide Medical				
Contract for Specified   X	Mentally III		(Transfer	X		No Formal Arrange- ment. Just call when				
Approximate Number of Inmates Receiving Medical Care   Seen by Physician   Seen by P	Drug Addicts			X		Contract for Specified	х	x		x
Approximate Number of Immates Receiving Medical Care   Seen by Physician   215   198   21   10   10   10   10   10   10   10	Alcoholics			X		Physician Employed			X	
Seen by Physician   93	Inmates Receiving Medical Care							Referred To Univ.		
Referred to Hospital   215   198   21   10   Coverage?   ?		93	365	24	45					
Referred to Hospital   68   70   10   10   10   10   10   10   10	Seen by Dentist						?	?	No	No
Control   Cont	Referred to Hospital	68	70	25	3	Physical Examination:	Voc	Vos	Voc	Ves
Colter   County   C		(Univ.	(Univ.				Soon as	Day	One	
Types of Medical   Facilities Used:   Facilities	Other	Exams	Exams		Exams			Admis- sion	77.	37
Private Local Hospital						Upon Complaint	Yes	Infirmary	res	ies
University Hospital		gency	gency		X	Regular	Yes	Yes	Yes	
Psychiatric Facility	University Hospital	-		x	x	Health Surveillance: Sanitary Inspections	v	v	x	x
City, County, Etc.   Medical Clinic	Psychiatric Facility			••				Usually		
Physician's Office	City, County, Etc.				75	By Whom	and	and	and	Service
Type of Health Personnel Used (Hours Per Month)								Sanita-		Director
Property   Property	Physician's Office	gencies			X		Commit-			
Physician, Full-time	Type of Health Person-						v	v	v	v
Physician, Full-time	nel Used (Hours Per Month)		No. Hrs.	No. Hrs.	No. Hrs.	Personal Hygiene				
Physician, Part-time   2	Physician, Full-time						X	X	X	X
Psychiatrist	Physician Bort time	9 16	. 6 40			Clothing & Bedding	X	x	X	
Dentist		ے <u>او</u>		o 95			x	x	x	x
Nurses 2 320 2 320 10 168 3 480 Are RX Drugs Dispensed to Inmates? Yes Yes Yes Yes  Med. Tech.  Social Workers 1 160 County 168 1 64 By Whom?  Social Workers 2 320 1 160 1 168 3 104  Psychologists 2 320 1 160 1 168 3 104  Are RX Drugs Dispensed to Inmates? Yes		1 24		1 28		•	21.	24	Λ	Λ
Med. Tech.   1   160				10 168	3 480	Are RX Drugs	Ves	Ves	Ves	Ves
Social Workers 1 160 Coun- 4 168 1 64 Officers Tech.	Med. Tech.		1 160	Each	ı		Correc-	R.N. or	Nursing	Nurses &
Psychologists 2 320 1 160 1 168 3 104 tant Pharma-	Social Workers	1 160	selors	4 168 Each	1 64		Officers Under Consul-	Tech.		
Indina	Psychologists	2 320		1 168	3 104					
				_ 30						

and Anamosa have a unit dose dispensing system. This system is being considered by the other two facilities. The advantages of the unit dose system are ease of accountability, automatic stop order capability and some cost containment.

#### Cost Factors

The operational cost of the present system of part-time medical coverage is quite significant when the factor of consultation is included. Psychiatric and other consultation is provided for essentially by staff at University Hospitals.

As mentioned much of the consultative work and associated therapy are performed at University Hospitals in Iowa City. This has had an escalating impact on the cost of care. A large portion of this cost is not for the medical care provided but rather is needed to underwrite the cost of transportation and guard services which are necessary when a resident leaves an institution. This cost item might be reduced through the use of local or nearby private consultants.

One principal reason for the heretofore limited use of local practitioners has been the threat of liability. The state affords no liability coverage (Attorney General's ruling) for other than full-time employees. Personal medical liability insurance rates are understood to increase markedly for the private physician if he agrees to provide services to residents or inmates in a correctional institution.

There are two basic approaches to the provision of health care for institutionalized people, according to the Committee's evaluation of reference information:

- 1. Full-time physician or physicians directing resident care. These practitioners are furnished appropriate consultative services, either locally or through an academic center. They are provided the supportive staffing, i.e., R.N.s, x-ray and lab technicians, aides, etc., necessary for the proper operation of a medical services program. The heavy demand for physicians in the private marketplace has made it difficult for institutions to attract and retain the full-time practitioner.
- 2. Part-time medical coverage of a correctional institution. This approach is followed in each of the Iowa facilities except for Oakdale. This arrangement necessitates the use of more than one physician if adequate coverage is to be available. The lack of continuity in care is cited as a weakness in this type of coverage in some instances. As previously noted, the provision of services of the parttime variety is hampered by the lack of liability protection for those involved. The Attorney General is reported to have ruled that part-time physicians are not protected by the State in event a malpractice suit is initiated against them by an inmate. Also, malpractice insurance carried by a private physician is reported to increase substantially in premium if the physician enters the prison to provide care. Aside from this obstacle, the several approaches to providing medical care on a part-time basis now operative in Iowa seem to be working adequately.

#### Committee Recommendations to the House of Delegates:

1. That the Iowa Medical Society encourage institutions to utilize private physicians or clinic groups, with the apparent logical and desirable approach in Iowa being that of a contractural arrangement to provide part-time services (except at the Oakdale facility).

2. That the Iowa Medical Society support a remuneration program for medical services in correctional facilities which is sufficient to attract well qualified physicians.

3. That the Iowa Medical Society urge assignment of

responsibility for the development and supervision of the health services program in a correctional institution to a medical director (even though he may be in a part-time capacity). This program should include a plan of care for each inmate to include an initial physical examination with annual re-examinations. Examinations should include appropriate laboratory and x-ray studies. Preventive health care should include indicated immunizations and vaccinations, as well as dental attention. Psychiatric studies should be made whenever necessary. An ongoing health education program should be implemented. The director of medical services should have a job description setting forth his responsibility and accountability.

4. That the Iowa Medical Society urge the state institutions to find mechanisms to provide professional liability coverage for all physicians involved in the health care of the inmate population. Included in this should be the consideration of legislation to make the state the defendant in any liability action against the physician.

5. That the Iowa Medical Society encourage the state institutions to explore the possibility of initiating formal training programs in paramedical fields, e.g., LPNs, nurses aides, etc., for interested inmates.

6. That the Iowa Medical Society suggest that the unit dose system for dispensing pharmaceuticals be established in all four facilities.

7. That the Iowa Medical Society recommend the institutions assure the availability of consultation from the various specialty areas of medicine, and that this be accomplished with an eye toward cost containment, but without jeopardizing the factors of safety, quality, etc.

8. That the Iowa Medical Society urge each institution to maintain a specific health care budget and endeavor to assure maximum utilization of the funding to provide quality services. Personnel, facilities and equipment should all be considered in the budgeting process.

9. That the Iowa Medical Society commend the state officials involved in this important work for their good efforts and assure them of the desire of the medical profession to provide advice and counsel as possible.

10. That the Iowa Medical Society consider the continuation of this or a similar committee to assess and report on health care provisions in city and county jails in Iowa. It is believed that county medical societies could provide valuable support to a state committee in an evaluation of this type.

In concluding this report, the members of the Committee on Health Care in Correctional Institutions wish to again express appreciation to the several state officials who provided much assistance and information during the past year. It is recommended that this report, depending on the consideration it is given by the 1974 House of Delegates, be distributed to appropriate state correctional personnel and to state legislators, to the American Medical Association and to other interested agencies.

Respectfully submitted,

E. M. SMITH, M.D., Chairman

C. N. HYATT, M.D.

D. R. KRUSCHWITZ, M.D.

E. C. LAIRD, M.D.

R. M. POWELL, M.D.

A. P. RANDOLPH, M.D.

W. T. SHULTZ, M.D.

#### COMMITTEE ON ALTERNATE DELIVERY SYSTEMS

(Referred to Reference Committee on Legislation and Medical Service.)

During the past year, the IMS President, with concurrence from the Board of Trustees, appointed a special committee on HMOs. In light of new state and federal

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legislation on Health Maintenance Organizations, it was considered imperative to establish a committee to deal with the complex issues surrounding this subject. The Committee has held two meetings, to discuss first, the establishment of rules and regulations to implement the Iowa HMO legislation, and secondly, to meet with officials of Blue Cross and Blue Shield to offer comments and guidance on its exploration of alternate delivery systems. A member of the Committee, Marvin Dubansky, M.D., of Des Moines, served on the Advisory Committee to the Department of Insurance and Department of Health which has drafted rules and regulations to implement the new Iowa law. These regulations have now been published in final form.

The IMS in 1971 requested Blue Shield to experiment with alternate delivery systems such as HMOs. Based on this action, Blue Cross and Blue Shield officials have met with various groups and organizations throughout the state to discuss and offer assistance where interest is indicated in the area of alternate delivery systems. Officials of Blue Cross and Blue Shield reviewed with the Committee an organizational structure which it felt would be the most appropriate approach to meeting the requirements of the new Iowa law. The organizational structure was accepted as a broad guideline by the Committee. The structure, in essence, would create a separate legal entity from either Blue Cross or Blue Shield, but if the Blues were to service the program, it would have representation on this legal entity. Copies of the proposed organizational structure are available to any physician who might be interested.

As encouraged by the IMS, representatives of Blue Cross and Blue Shield upon request have met with county medical societies, hospital medical staffs and physician groups to discuss the broad area of alternate delivery systems. The Committee has been provided with a detailed report on these contacts and continues to support efforts to experiment in alternate delivery systems, for the Committee is well aware that the basic definition of an HMO can encompass several alternate proposals. It should be pointed out that legislation does not require a specific type of organization, but rather a set of functions. There is great latitude in terms of what type of organization may qualify, because neither state nor federal legislation limits the program to a particular organizational or managerial form, delivery mode, reimbursement mechanism or enrollee payment of financing source. Blue Cross and Blue Shield is discussing with providers three basic approaches. First, a delivery system "without walls" which could be administered by a county medical society and include comprehensive out-patient and in-patient services, organized by the providers with appropriate peer review and necessary quality control standards provided by physicians. Second, a program similar to that existing under Wisconsin Physicians Service, the Blue Shield plan in Wisconsin owned by the State Medical Society. The program is a group practice project, but the patients under the program are integrated with the physicians' private fee-for-service patients. Certain services are covered on a pre-paid capitation basis, and others on a fee-for-service basis. Individual physicians can elect to participate or not participate in the program. The third and perhaps the one most often referred to is the Kaiser-Permanente type of program. It is not anticipated that there will be a great deal of interest in this approach in Iowa. However, the option is available where interest is sufficient.

The Committee readily acknowledges that all the national health insurance proposals presently before Congress include authorization for payment to an HMO type program. The Committee believes that physicians should

continue to exercise leadership and provide alternatives for care designed by physicians and other providers on a voluntary basis, rather than awaiting action at a federal level which could well dictate the form that any alternate delivery system might take.

Based on previous House of Delegates action encouraging the Blues to experiment with alternate delivery systems, the Committee has adopted the following principles to aid the Blues in future activity in this area:

1. Continue to meet and encourage the development of

alternate delivery systems by physicians.

2. Not meet with any physicians specifically on alternate delivery systems without written invitation. When accepting invitations, be certain that the county medical society is aware.

3. Actively seek county medical societies or hospital medical staffs who will be willing to develop non-walled

fee-for-service alternate delivery systems.

4. Continue to keep the state medical society's Committee aware of activities and to seek guidance from them.

The Committee discussed in some detail with officials of Blue Cross and Blue Shield a proposed program which is in an active discussion stage with a medical group in Iowa. Blue Cross and Blue Shield will be conducting a feasibility study to determine whether or not a program in this specific location would be viable. Such discussions will include continued meetings with the medical clinic, the hospital staff and the county medical society, as well as determining the reaction and possible interest of individual practicing physicians from the surrounding area. In addition, a marketing feasibility study will need to be undertaken, including the probable cost of any program developed. Also, the Committee will be in a position to comment on the type of promotional enrollment material that would ultimately be used in this project if it is in fact undertaken. The results of these studies will be reported back to the Committee for comment. The Iowa Medical Society will thereby be kept apprised of how Blue Cross and Blue Shield are carrying out the suggestions of the House of Delegates.

The Committee has recommended to the President and the Board of Trustees that the name of the Committee be changed from its original title of IMS HMO Advisory Committee to the Committee on Alternate Delivery Systems. The Committee believes this title more adequately described its charge. The term HMO is too often misunderstood as being limited to a closed panel, pre-paid, capitation system, when in fact the approaches being dis-

cussed include several other alternatives.

Respectfully submitted,
J. F. Bishop, M.D., Chairman
M. H. Dubansky, M.D.
Erling Larson, Jr., M.D.
K. E. Lister, M.D.
J. K. MacGregor, M.D.
P. M. Seebohm, M.D.
R. L. Wicks, M.D.

At this point, Dr. Schlaser read a letter from American Association of Medical Assistants, State of Iowa, expressing regret that it could not sponsor a coffee bar. They extended best wishes to all members of the House of Delegates for a most successful meeting.

#### RESOLUTIONS

DES MOINES-LOUISA COUNTY MEDICAL SOCIETY NO. 1. PSRO REPEAL AND PEER REVIEW

(Referred to Reference Committee on Legislation and Medical Service.)

Whereas. We believe the Professional Standards Review amendment to Title XI of the Social Security Act enacted as Public Law 92-603 was hastily enacted by the 92nd Congress on the false premises (1) that medical care in the United States is of inferior quality, and (2) that physicians are responsible for the increase in cost of medical care; and

WHEREAS, The statute intends quality medical services, it does, in fact, mainly address itself to cost-control; and

Whereas, We believe the Professional Standards Review section of Public Law 92-603 will, in fact, interfere with physicians' ability to make good medical judgements: and

WHEREAS, We believe the Professional Standards Review section of Public Law 92-603 will destroy the confidential nature of the patient-physician relationship; and

Whereas, We believe the Professional Standards Review section of Public Law 92-603 may well be in violation of the principles of medical ethics of the American Medical Association, which state "a physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgement and skill or tend to cause a deterioration of the quality of medical care"; therefore

Resolved, That the Iowa Medical Society work for the repeal of the PSRO Section of P.L. 92-603 through all methods available; and be it further

Resolved, That the Iowa Medical Society urge that its members participate in every way possible in all activities of existing and time-honored mechanisms of local voluntary peer review to make certain that our patients will continue to receive the highest quality medical care possible; and be it finally

Resolved, That this resolution be distributed to the members of the House of Delegates of American Medical Association and to the members of the Senate and House of Representatives.

#### POLK COUNTY MEDICAL SOCIETY NO. 2. THE AVAILABILITY OF THIRD PARTY FEE GUIDES

(Referred to Reference Committee on Legislation and Medical Service.)

WHEREAS, Physicians are presently under a discriminatory fee freeze (Phase IV), and the Administration has recommended that the fee freeze should apply to physicians until the passage of national health insurance, and

WHEREAS, The Iowa Medical Society has a policy discouraging third parties from releasing fee information because of the tendency of such guidelines to become rigid and inflexible fee schedules, and for physicians to bill at these levels instead of establishing their own usual fees based on individual circumstances, and

Whereas, This probability is no longer applicable in view of the government's physician fee freeze which permits only a 4% aggregate increase and a 10% increase on any one service, therefore be it

Resolved, That the Iowa Medical Society require Blue Shield and request private insurance companies to release to county medical societies, the Iowa Foundation for Medical Care, and individual doctors the customary fee screens or Relative Value Schedule including the dollar amount per unit used under health coverage programs, and be it further

Resolved, That the Iowa Medical Society take the necessary steps in order to obtain the cooperation of all third parties in making this information available.

#### POLK COUNTY MEDICAL SOCIETY NO. 3. HANDLING OF SUPPLEMENTAL REPORTS

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

Whereas, The reading of supplemental reports is tedious and time consuming to all involved, and

WHEREAS, This resolution, if approved, would further streamline the activities of the House, while in assembly, and allow additional time for legislative activity, and

Whereas, This resolution, if approved, would enable delegates to obtain constituent opinion on the legislative aspects of the supplemental reports, a custom not presently possible due to geographic and time impediments, therefore be it

Resolved, That other than the Presidential Address, supplemental reports and other remarks be presented in written form prior to the convening of the House of Delegates, and mailed (to the delegates) 10 days prior to the convening date.

#### DICKINSON COUNTY MEDICAL SOCIETY NO. 4 SUPPLYING OF FEE DATA

(Referred to Reference Committee on Legislation and Medical Service.)

Resolved, That Blue Shield be requested to provide to the Iowa Medical Society a complete Medicare regional profile on all medical fees and additionally supply to each physician his individual profile on his written request.

### WAYNE COUNTY MEDICAL SOCIETY

NO. 5. QUALIFICATIONS FOR ELECTION OF DISTRICT COUNCILOR

(Referred to Reference Committee on Articles of Incorporation and By-Laws.)

Whereas, The Articles of Incorporation and By-Laws of the Iowa Medical Society, as amended and substituted through 1973, provide that a physician living an inconvenient distance from his component society may hold membership in a more convenient society, provided no objection is made by the society in whose jurisdiction he resides; and

Whereas, The aforementioned Articles of Incorporation and By-Laws (Section 15, Page 14), dictate that, "Each councilor shall have been a resident of the District which he is elected to represent for at least two years preceding his election. . . . "; and

WHEREAS, It is the feeling of this county society that a member of a county medical society for two years should be eligible for all offices of the state medical society so long as he is qualified in all other respects, therefore

Resolved, That Section 15 of the Articles of Incorporation and By-Laws, beginning with line 8 of that Section be modified to read: "Each councilor shall have been a member of the District which he is elected to represent for at least two years next preceding his election and his permanent removal as a member of that District shall automatically create a vacancy in his office.'

#### LINN COUNTY MEDICAL SOCIETY NO. 6. COMPENSATION FOR IMS PRESIDENT

(Referred to Reference Committee of Board Trustees.)

Whereas, The President of the Iowa Medical Society devotes much time and energy to the affairs of the Society; and

Whereas, This loss of time from his practice represents a great financial sacrifice; and

Whereas, This financial loss is not compensated by the

mere paying of expenses for the President in his conduct of the affairs of the Society; and

Whereas, The consequent financial loss to the President and his clinical associates may be a significant factor in limiting the number of individuals ready and willing to offer their services as President of the Society; therefore be it

Resolved, That the Executive Committee of the Iowa Medical Society investigate the feasibility of reasonable compensation to the President of the Iowa Medical Society for time lost from his practice while engaged in the affairs of the Society.

### DUBUQUE COUNTY MEDICAL SOCIETY NO. 7. PEER REVIEW BY SPECIALTY

Whereas, Fees are being judged by physicians who have bias related to their own interests inserting jealously of procedure and charges; and

WHEREAS, Fees are presently being judged in reference to different types of billing, e.g., post op visits not included in charge, therefore be it

Resolved, That peer review performed by the Iowa Foundation for Medical Care be done by specialty.

### DUBUQUE COUNTY MEDICAL SOCIETY NO. 8. HONORARY MEMBERSHIP IN IMS

(Referred to Reference Committee on Articles of Incorporation and By-Laws.)

WHEREAS, A physician wishing to retire should not be burdened with paying dues to the IMS; and

WHEREAS, Active participation in committees should be encouraged for the retired physician, and he should not feel obligated to pay dues to retain the privilege after retirement; and

Whereas, Our senior physicians should be granted favors in our medical society as senior citizens are granted reduced rates in other segments of our society at large; therefore be it

Resolved, That honorary membership in the IMS be given to a member wishing to retire at age 65 if he has paid dues for a cumulative 20-year period.

### DUBUQUE COUNTY MEDICAL SOCIETY NO. 9. PRECERTIFICATION OF HOSPITAL ADMISSIONS

(Referred to Reference Committee on Legislation and Medical Service.)

Whereas, Precertification of hospital admissions would require duplication of physician work as a lesser-trained individual could not validly make such a medical judgement; and

WHEREAS, Precertification adds a feeling of doubt to patient and physician relationship doing harm to a patient at a crisis time when he needs trust in his doctor; therefore be it

Resolved, That precertification of hospital admissions be opposed vigorously.

### WEBSTER COUNTY MEDICAL SOCIETY NO. 10. APPLICATION OF REGULATORY MEASURES

(Referred to Reference Committee on Legislation and Medical Service.)

Resolved, That the Iowa Medical Society request the AMA House of Delegates to make it policy to withhold support for any governmental regulations which seek to limit "overutilization" of medical and hospital facilities until and unless the same regulations are made applicable

to all government-operated hospitals, including Veterans Administration and Walter Reed Hospital in Washington, D.C.

### WEBSTER COUNTY MEDICAL SOCIETY NO. 11. THIRD PARTY RESPONSIBILITY

(Referred to Reference Committee on Legislation and Medical Service.)

Resolved, That the Iowa Medical Society House of Delegates make it a policy to shift the ever-increasing burden of "policing" medical and hospital insurance programs, and various other "third party" payment programs, to agents of the third parties, recognizing that payment or nonpayment of benefits is a fiscal matter not necessarily related to medical needs of doctors and patients; and be it further

Resolved, That physicians and medical organizations be prepared to assist in preventing abuses by establishing general guidelines for the third parties, leaving the actual enforcement of these guidelines and the granting or withholding of financial benefits to the paid representatives of the third parties.

# WEBSTER COUNTY MEDICAL SOCIETY NO. 12. SUPPORT OF COUNTY SOCIETIES IN THIRD PARTY ACTIVITIES

(Referred to Reference Committee on Legislation and Medical Service.)

Whereas, It has been shown that state and national medical societies may legally perform for their members all services provided for members of the labor unions; and

WHEREAS, There is growing dissatisfaction on the part of members of the Iowa Medical Society with our organizational performance in dealing effectively for us with third parties, such as insurance companies, government agencies, and the like; and

Whereas, Many members are now turning to medical unions for effective representation in these areas; therefore be it

Resolved, That the officers and Board of Trustees of the Iowa Medical Society now begin a coordinated program to make the Society more effective and more responsive to the needs of our members in dealings with third parties; and be it further

Resolved, That the staff and legal counsel of the Society be made available to support component county societies or individual members when conflicts arise with third parties over fee schedules, hospital admission policies and any other matters which affect physicians generally throughout the state.

### WRIGHT COUNTY MEDICAL SOCIETY NO. 13. SUPPORT FOUNDATION AS IOWA PSRO

(Referred to Reference Committee on Legislation and Medical Service.)

Whereas, The PSRO provisions of Public Law 92-603 are indeed law and the prospects of that law being repealed or changed are only in the distant future, if at all: and

WHEREAS, The prospect of *physicians* reviewing all medical Government programs, including the present Medicare and Medicaid is much more attractive than the presently unsatisfactory lay bureaucracy of the present carriers (which will cease on 1/1/76); and

WHEREAS, The Iowa Foundation for Medical Care has, with great foresight, prepared the way to function as a PSRO; therefore be it

Resolved, That the Wright County Medical Society endorsed the choice of the Iowa Foundation for Medical

Care as the designated PSRO for Iowa; and be it further Resolved, That our AMA delegates be instructed to carry for us all a more constructive attitude about PSRO to the AMA meeting in Chicago this 1974.

#### KURT HAHN, M.D., DELEGATE, DES MOINES-LOUISA COUNTY MEDICAL SOCIETY NO. 14. PSRO-IMF

(Referred to Reference Committee on Legislation and

Medical Service.)

Whereas, Implementation of the PSRO law will inject the element of coercion into programs of peer review conducted by the medical profession on a voluntary basis, and

WHEREAS, Compulsion and quality medical care are

mutually contradictory, and

WHEREAS, Officials of HEW are engaging in a reprehensible misrepresentation of fact when they say local doctors will control PSROs and set the standards of medical practice that PSROs will be required to force upon the

practicing physician, and

WHEREAS, Physicians of Iowa, through the Iowa Medical Foundation can develop and carry out a voluntary state-wide peer review program that will enhance the quality of medical care, not debase it as will the coercive PSRO program with its compulsory, preset norms of diagnosis and care, now therefore be it

Resolved, That all medical organizations that have applied for recognition as a PSRO be asked to immediately withdraw their application and return any federal funds that have been accepted so that the independence and integrity of the medical profession can be assiduously

preserved, and be it further

Resolved, That organizations of physicians, as well as individual physicians, be urged not to negotiate any contracts for performing any services or participating in any activities under the PSRO law, and be it further,

Resolved, That the Iowa Medical Society, through the Foundation, proceed to establish a functioning statewide peer review program outside the PSRO law designed to improve the quality of medical care in Iowa on a continuing basis and to preserve the climate for innovation in medicine and to safeguard the freedom of Iowa physicians to practice medicine without disruptive government or other third-party interference, and be it further

Resolved, That the Iowa Medical Society and all component societies work vigorously with Iowa Senators and Representatives in Congress to achieve repeal of the

punitive PSRO law, and be it further

Resolved, That the Iowa Medical Society conduct a continuing program to inform the public and the profession of the deleterious effects of the PSRO law, and be it further

Resolved, That each member of the Iowa Medical Foundation be assessed \$100.00 for the purpose of carrying out the objectives of this resolution, and be it further

Resolved, That Iowa delegates to the American Medical Association House of Delegates be instructed to vote for a clear-cut AMA policy to require the Board of Trustees and Staff to work vigorously for repeal of PSRO and to immediately cease collaboration with HEW to implement the PSRO law.

### POLK COUNTY MEDICAL SOCIETY NO. 15. HOUSE OF DELEGATES SCHEDULE

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

WHEREAS, Most physicians would find it easier to be away from their office over the entire weekend, mainly

Friday, Saturday and Sunday rather than Saturday, Sunday and Monday, therefore be it

Resolved, That future House of Delegates meetings not already contracted for, be held on Friday afternoon, Saturday and Sunday with the first meeting of the House on Friday afternoon; Reference Committees on Saturday and the second session of the House of Delegates on Sunday.

### A. W. BOONE, M.D., DELEGATE, SCOTT COUNTY NO. 16. RECERTIFICATION EXAMINATION

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

Whereas, There is much question with regard to the validity of another cognitive type examination with regard to the measurement of physician performance; and

WHEREAS, The implication of recertification examinations on medical practice is not clear; and

WHEREAS, Recertification of continuing education is much more flexible and the results of such requirements have not yet been completely studied; and

WHEREAS, Local periodic study of a physician's performance would possibly be a more accurate measurement of a physician's continuing performance; therefore be it

Resolved, That the AMA Council on Medical Education be instructed to study the above factors with regard to recertification and bring back the results of this study to the House of Delegates.

#### LIFE AND ASSOCIATE MEMBERSHIPS

### LIFE MEMBERSHIP RECOMMENDED ON THE BASIS OF FIFTEEN CONSECUTIVE YEARS MEMBERSHIP

County Jefferson Polk

Name Ludwig Gittler, M.D., Fairfield Harold C. Bone, M.D., Des Moines Donald H. Kast, M.D., Des Moines Benjamin F. Kilgore, M.D., Des Moines Elmer A. Vorisek, M.D., Eureka Springs, Ark.

### ASSOCIATE MEMBERSHIPS RECOMMENDED ON THE BASIS OF RETIREMENT OR INCAPACITATION

Name

County Black Hawk Boone Chickasaw Davis

Harold O. Gardner, M.D., Waterloo John C. Herman, M.D., Boone Edwin C. O'Connor, M.D., New Hampton Charles D. Fenton, M.D., Bloomfield Edwin O. Gilfillan, M.D., Englewood, Fla.

Des Moines-Louisa Dickinson Harrison Marshall Pottawattamie-Mills

Carl J. Lohmann, M.D., Burlington Francis B. O'Leary, M.D., Spirit Lake Clemmet W. Byrnes, M.D., Dunlap Adrian J. Schroeder, M.D., Marshalltown

Pottawattam Mills Scott Sioux Story

Abbott M. Dean, M.D., Council Bluffs Samuel J. Altman, M.D., Davenport Arthur W. Shafer, M.D., Davenport Cornelius B. Murphy, M.D., Alton Albert R. Abbott, M.D., Remer, Minn. Charles M. Blackburn, M.D., Ames John G. Grant, M.D., Ames Cecil V. Hamilton, M.D., Ames Gail M. Proffitt, M.D., West Des Moines Gail M. Proffitt, M.D., Ottumwa Edson E. Moore, M.D., Fort Dodge

Wapello Webster

The physicians nominated for each of these membership categories were approved unanimously.

At this point, Dr. Caraway introduced Dr. Frederick Lake, President of the Illinois State Medical Society. Dr. Rubin Flocks, IMS President, then addressed the delegates. His remarks are published on page 267 of this issue of the JOURNAL.

Following the remarks by Dr. Flocks, Dr. Caraway announced the meeting places for the various reference committees. Delegates were informed the House of Delegates would convene Monday, May 13, at 8:30 a.m. The House adjourned at 5:20 p.m.

#### MONDAY SESSION, MAY 13, 1974

The Monday session of the House of Delegates was called to order at 8:45 a.m. The House approved the taking of attendance by registration cards. There were

103 delegates, 18 voting alternates and 10 ex-officio members present. Delegates' packets and ballots were distributed at the time of registration.

COUNTY	DELEGATE	COUNTY	DELEGATE	COUNTY	DELEGATE
Appanoose Black Hawk	A. S. Owca G. R. Clark R. S. Gerard A. M. Dolan* R. R. Roth A. W. Woodward M. N. Williams	Harrison Jasper Jefferson Johnson	J. W. Barnes T. E. Kiernan W. C. Baumann R. C. Brown D. E. Schnetzler* J. B. Wilcox* L. G. Rigler*		J. J. Kelso H. E. Eklund J. D. German* R. C. Smith D. C. Young R. W. Overton A. N. Smith
Boone Bremer Buena Vista Cass Cerro Gordo	R. E. Hedican, Jr. E. E. Linder V. H. Carstensen E. C. Laird T. J. Payne R. M. Powell D. D. Van Etten W. C. Rosenfeld*		K. J. Judiesch C. E. Radcliffe P. M. Seebohm C. A. Skaugstad R. D. Whinery K. D. Dolan R. E. Rakel W. J. Tegler		C. H. Denser, Jr.* D. L. Sweem D. O. Newland E. M. Smith* Wallace Rindskopf* J. S. Conner* H. J. Smith* R. F. Birge*
Cherokee	H. W. Alcorn G. H. West, Jr. G. E. Michel	Jones Lee Linn	A. P. Randolph J. E. McGee C. R. Aschoff	Pottawattamie-Mills	Marshall Flapan
Clarke Clayton Clinton	J. D. Kimball J. D. Compton		R. M. Quetsch R. L. Sedlacek* T. J. McIntosh	Poweshiek	M. E. Olsen G. L. Neligh H. R. Light
Crawford	G. L. York G. T. Schmunk D. J. Soll		R. W. Conkling J. H. Lohnes	Scott	J. C. Barker A. W. Boone
Dallas-Guthrie Davis Decatur-Ringgold	E. E. Lister H. M. Perry E. E. Gamet	Mahaska	W. J. Robson R. A Sautter S. A. Smith		J. C. Donahue J. H. Sunderbruch* Erling Larson, Jr.*
Delaware	D. E. Mitchell J. E. Tyrrell	Marion Marshall	J. E. Griffin* W. T. Shultz	Shelby Sioux	J. H. Spearing E. B. Grossmann, Jr.
Dickinson Dubuque	D. F. Rodawig, Jr. J. W. White R. T. Melgaard K. K. Hazlet	Monona Monroe Montgomery	C. D. Bendixen* J. L. Garred D. N. Orelup Oscar Alden	Story	W. R. Bliss W. A. Baird Charles Jons
Floyd Franklin	E. E. Schmiedel R. E. Munns	Muscatine O'Brien	K. E. Wilcox R. L. Zoutendam	Tama Union-Taylor	A. J. Havlik R. H. Kuhl
Grundy Hancock-Winnebag	D. R. Kruschwitz o L. R. Fuller	Pocahontas Polk	James Gannon M. H. Dubansky John Hess, Jr.	Wapello Wayne	L. E. Coppoc R. D. Schrantz K. A. Garber
Hardin	S. M. Haugland T. C. Graham		D. J. Walter G. B. Purnell*	Webster	H. H. Kersten J. F. Kelly
* Alternate			J. L. Fatland M. E. Thoman	Woodbury Wright	P. M. Cmeyla C. P. Hawkins

#### LIAISON DELEGATES

S. P. Leinbach

C. W. Seibert

#### EX-OFFICIO MEMBERS OF THE HOUSE

R. H. Flocks	Hormoz Rassekh
R. L. Wicks	L. D. Caraway
R. M. Chapman	J. R. Anderson
V. L. Schlaser	J. M. Rhodes, Sr
J. F. Bishop	K. E. Lister

Dr. Schlaser read the minutes of the May 11 meeting of the House of Delegates and the House approved them.

The election of officers occurred and the following physicians were chosen:

President-elect
Vice President
Trustee
Trustee (1 year)
Speaker of the House
Vice Speaker of the
House
Delegates to AMA

Councilor, District 2

V. L. Schlaser, M.D., Des Moines T. E. Kiernan, M.D., Newton J. H. Kelley, M.D., Des Moines J. F. Bishop, M.D., Davenport L. D. Caraway, M.D., Amana

R. D. Whinery, M.D., Iowa City Erling Larson, Jr., M.D., Davenport L. W. Swanson, M.D., Mason City W. V. Wulfekuhler, M.D., Mason City Councilor, District 3 Councilor, District 7 Councilor, District 8 Councilor, District 9 Councilor, District 12 Blue Shield Liaison Delegates to IMS D. F. Rodawig, Jr., M.D., Spirit Lake J. E. Tyrrell, M.D., Manchester R. L. Kent, M.D., Fort Madison S. A. Smith, M.D., Oskaloosa E. E. Linder, M.D., Ogden C. W. Seibert, M.D., Waterloo J. D. Ver Steeg, M.D., Des Moines

Dr. Caraway commended the members of the Reference Committees, invited delegates to next meeting of House of Delegates to serve on Reference Committes, and asked inquiries be directed to Speaker, IMS Headquarters Office. He then informed delegates of the proper procedure for debate and voting on Reference Committee Reports.

#### REFERENCE COMMITTEE REPORTS

The following Reference Committee reports were acted upon by the House of Delegates.

#### **BOARD OF TRUSTEES**

The Board of Trustees seated as a Reference Committee considered Resolution No. 6 introduced by the Linn County Medical Society; Subject—Compensation for the IMS President. The only discussant was a delegate from Linn County. He explained to the Board of Trustees that in fact the resolution emanated from the Seventh Councilor District, not just Linn County alone, and its primary purpose was to ascertain the existing formula for compensating the President and to make certain he was being appropriately reimbursed for expenses incurred in pursuit of the business of the Iowa Medical Society.

It was explained that the present formula for reimbursement provides for total expenses of the President in conducting the business of the Medical Society. A new formula was suggested that seemed to be acceptable to the Linn County delegate, with unanimous concurrence by the Board of Trustees.

RECOMMENDATION: Resolved, That when the President or Chairman of the Board of Trustees, or any member of the Board serving in their behalf, are attending meetings in the interest of the Iowa Medical Society they should be reimbursed not only their expenses but those of their spouses.

Mr. Speaker, I move adoption of this resolution.

Respectfully submitted,

J. F. BISHOP, M.D., Chairman

A. J. HAVLIK, M.D.

J. H. KELLEY, M.D.

R. H. Flocks, M.D.

R. L. Wicks, M.D.

R. M. CHAPMAN, M.D.

V. L. Schlaser, M.D.

T. A. Burcham, M.D.

#### ARTICLES OF INCORPORATION AND BY-LAWS

The Reference Committee on Articles of Incorporation and By-Laws convened its open hearing at 8:45 a.m. on Sunday, May 12, to receive comments on the resolutions and reports referred to it. The opinions submitted by members of the Board of Trustees and others during the hearing were helpful to the Reference Committee in compiling those recommendations which are presented in this report.

RESOLUTION NO. 5—INTRODUCED BY
THE WAYNE COUNTY MEDICAL SOCIETY
QUALIFICATIONS FOR ELECTION OF DISTRICT COUNCILOR

This resolution was prompted by a circumstance in one councilor district wherein a physician member of said district was found ineligible to hold the office of councilor due to his residence in a county adjacent to but not part of the district in question. The resolution seeks to alleviate the problem in this and possible future instances. The necessary modification in the Articles is possible through the change of a single word and the change seems appropriate. In the interest of protocol, and having been advised by the sponsor of the resolution that timing is not a critical factor, the Reference Committee believes the usual channels should be followed in making this change in the Articles of Incorporation and By-Laws.

RECOMMENDATION: The Reference Committee supports Resolution No. 5 and recommends adoption of the following implementing resolution:

Resolved, That the Standing Committee on Articles of Incorporation and By-Laws submit formally to the next session of this House of Delegates the following amendment to the Articles: That Article IV, Section 15 of the Articles be amended so that the second sentence thereof shall read as follows:

Article IV, Section 15. . . . Each councilor shall have been a (word resident was deleted) member of the District which he is elected to represent for at least two years next preceding his election and his permanent removal from that District membership shall automatically create a vacancy in his office.

Mr. Speaker, I move the adoption of the foregoing resolution, as amended.

The Resolved was amended to insert the word "membership" after the words "his permanent removal from that District."

SUPPLEMENTAL REPORT OF COMMITTEE ON ARTICLES
OF INCORPORATION AND BY-LAWS
SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES
(Section 4, Page 4)

The goal of attracting new physicians into active membership in the Iowa Medical Society by providing them a financial inducement is regarded by the Reference Committee as laudable and worthy of experimentation. In its discussion, the Reference Committee emphasized that this is one way of stimulating participation, but that it should be only one facet of a broad and ongoing program to stimulate the interest and involvement of new physicians in the organized activity of the medical profession.

In its consideration of these reports and Resolution No. 8, the Reference Committee concluded the recommendations should be expanded to provide financial considerations to physicians in their senior years.

RECOMMENDATION NO. 1: The Reference Committee recommends that the Resolution submitted by the Committee on Articles of Incorporation and By-Laws be approved in an expanded form to include the language shown in parenthesis,

Resolved, That Article VII, Section 1 of the Articles be amended to read as follows:

Article VII, Section 1. Funds for meeting the expenses of this Society shall be raised by annual per capita dues and may also be raised by special dues upon each component society, which dues shall be fixed by the House of Delegates. Nothing in these Articles or in the By-Laws shall preclude the House of Delegates, the House having first heard the recommendation of the Board of Trustees thereon, from fixing the dues for student members on other than an annual basis or from fixing the dues for student members, interns, residents or active members in their first two years of active practice (or active members who have attained at least age 70), at an amount less than the regular dues. Funds may also be raised by voluntary contributions, from the Society's publications, or in any other manner approved by the House of Delegates.

Mr. Speaker, I move the adoption of the foregoing resolution.

RECOMMENDATION No. 2: In acting to implement portions of the provisions set forth in the preceding resolution, the Reference Committee recommends the proposal of the Board of Trustees be sustained and the following resolution be approved:

Resolved, That the annual per capita dues of an active member of the Iowa Medical Society who is engaged in his or her first two years of active practice are hereby established at one-half of the dues charged other active

members, and that the term "first two years of active practice" shall mean practicing as a physician for remuneration in any capacity, in or outside the State of Iowa, after graduation from medical school but not including practice as an intern, resident, member of the Armed Forces or in service alternative to that in the Armed Forces.

Mr. Speaker, I move the adoption of the foregoing resolution.

# RESOLUTION NO. 8—INTRODUCED BY DUBUQUE COUNTY MEDICAL SOCIETY HONORARY MEMBERSHIP IN IMS

This resolution prompted extensive discussion by the Reference Committee of the several classifications of Society membership, i.e., Life, Honorary, and Associate. The Committee was advised by a representative of the county society sponsoring Resolution No. 8 that the category of Life membership was actually the one being submitted for consideration.

The Reference Committee is fully in accord with the intent of the resolution which is to maximize the active participation of senior members of the Iowa Medical Society, while not imposing an undue financial burden on them at a time when their incomes may be in a reduced state. The Reference Committee believes the intent of this resolution is met by the language, if adopted, which is contained in the Resolution set forth in Recommendation No. 1 above, if in time the Board of Trustees sees fit to recommend to the House of Delegates a modification in dues payments for senior physicians.

RECOMMENDATION: In lieu of the foregoing discussion, the Reference Committee submits the following resolution:

Resolved, That Resolution No. 8 be not adopted.

Mr. Speaker, I move the adoption of the foregoing resolution.

RECOMMENDATION: The Reference Committee further proposes the following:

Resolved, That the Chairman of the Board of Trustees and the Secretary of the Iowa Medical Society be and they hereby are authorized and directed to sign, acknowledge and publish the Amendments, adopted by the House of Delegates at this meeting, as the Fifteenth Amendments to the Articles of Incorporation, as amended, and to do all other things required by law or otherwise to execute, complete and place in lawful effect such Amendments.

 $\mbox{Mr.}$  Speaker, I move the adoption of the foregoing resolution.

This concludes the Report of the Reference Committee on Articles of Incorporation and By-Laws.

Respectfully submitted, E. C. Laird, M.D., Chairman W. A. Baird, M.D. K. A. Hahn, M.D. E. E. Schmiedel, M.D.

J. W. WHITE, M.D.

# REPORTS OF OFFICERS AND MISCELLANEOUS BUSINESS

The Reference Committee on Reports of Officers and Miscellaneous Business received testimony on Sunday, May 12, 1974, from member physicians and guests on the various items referred to it, and the following recommendations are submitted relating to the various reports and resolutions considered:

#### SUPPLEMENTAL REPORT OF JUDICIAL COUNCIL; SUPPLEMENTAL REPORT OF BOARD OF TRUSTEES STUDENT IOWA MEDICAL SOCIETY

Supplemental Report of Judicial Council re charter for Student Iowa Medical Society:

RECOMMENDATION: The Reference Committee recommends that the following resolution be adopted:

Resolved: The House of Delegates hereby issues a charter to the Student Iowa Medical Society as a component society of the Iowa Medical Society.

Mr. Speaker, I move adoption of this resolution.

Supplemental Report of Board of Trustees re dues for SIMS members:

RECOMMENDATION: The Reference Committee recommends that the following resolution be adopted:

Resolved, That dues for student members of the Iowa Medical Society are hereby established at \$5.00 per member to be paid one time only.

Mr. Speaker, I move the adoption of this resolution.

The Reference Committee is pleased to acknowledge the formal establishment of the Student Iowa Medical Society, and is hopeful that its members will become members and active participants in the Iowa Medical Society.

### SUPPLEMENTAL REPORT OF BOARD OF TRUSTEES IMS MEMBERSHIP DUES

RECOMMENDATION: In view of the recent study of IMS finances, and previous House approval and guidelines for future fiscal planning, the Reference Committee recommends that the following resolution be adopted:

Resolved, That IMS membership dues for 1975 be established at \$200 per member.

Mr. Speaker, I move the adoption of this resolution.

The Reference Committee is cognizant of the time and effort put forth by all members of the Board of Trustees in overseeing the business affairs and the overall operation of the Society, and commends them for performing their responsibilities in a dedicated and conscientious manner.

# SUPPLEMENTAL REPORT OF MEDICO-LEGAL COMMITTEE PROFESSIONAL LIABILITY INSURANCE COVERAGE FOR IOWA PHYSICIANS

The Reference Committee took note of the "good news" and the "bad news" contained in the informational report of the Medico-Legal Committee re professional liability coverage for physicians in Iowa—i.e., although there has been an increase in premium rates for malpractice insurance, coverage still is available from several carriers at rates somewhat less than in other sections of the country.

RECOMMENDATION: The Committee recommends the adoption of the following resolution:

Resolved, That the IMS Medico-Legal Committee should (1) conduct a survey of state medical associations to secure an accurate reading on the status and types of malpractice coverages available elsewhere; (2) seek a conference with representatives of the Iowa State Bar Association on the feasibility of the arbitration or screening panel system; (3) maintain ongoing contact with those companies now writing individual professional liability coverage in Iowa in an effort to demonstrate the profession's desire to maintain surveillance over developments and offer medical expertise as possible.

Mr. Speaker, I move the adoption of this resolution.

#### SUPPLEMENTAL REPORT OF THE SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH STATEMENT RE DISEASE ERADICATION PROGRAM

The Reference Committee calls the attention of the House to the following editorial change in the statement of the Iowa State Department of Health on the Disease Eradication Program which is included in the Supplemental Report of the Committee on Maternal and Child Health, line #19, page 3: after the word "of" and before the word "diphtheria," add the word "poliomyelitis."

RECOMMENDATION: The Reference Committee recommends the adoption of the following resolution:

Resolved, That the Iowa Medical Society endorses the statement on Disease Eradication Program as devised by the Iowa State Department of Health, and authorizes the Subcommittee on Maternal and Child Health to work with the Department of Health in its implementation.

Mr. Speaker, I move the adoption of this resolution.

#### SUPPLEMENTAL REPORT OF COMMITTEE ON DELIVERY OF HEALTH SERVICES; SUPPLEMENTAL REPORT OF BOARD OF TRUSTEES DELIVERY OF HEALTH SERVICES

The Reference Committee heard additional testimony from both the chairman of the Committee on Delegation of Authority and a member of the Dallas-Guthrie County Medical Society re the following 1973 Resolution of the D-G County Medical Society:

"Resolved, That 'Rural Medical Family Practice Units' be required to be manned by physicians 24 hours per day, so that adequate, continuous medical care may be rendered to the people in the rural areas, and near-by physicians will not be asked to see these patients after

normal daytime office hours.'

The Reference Committee is in sympathy with the sentiments expressed by both the Committee and the D-G County Medical Society re the perplexing problems involved in providing continuous medical coverage to the citizens of our state; further, it is aware that considerable attention is being given by appropriate committees and officers of the IMS to programs currently underway designed to enhance the productivity of physicians through the use of physician's assistants, and by extending the role of the nurse in patient care. In this regard, special attention was given by the Committee to sections of the Board of Trustees Supplemental Report pertaining to past and future meetings scheduled with the State Board of Medical Examiners to discuss rules and regulations governing physician's assistants, as well as anticipated sessions with representatives of the Iowa Nurses' Association and Board of Nursing Examiners to discuss developments with respect to the expanded role of the nurse in patient care.

RECOMMENDATIONS: In light of recent developments and long-range concerns of the medical profession relating to the utilization of physician's assistants and nurses by physicians, the Reference Committee recommends that

the following resolutions be adopted:

Resolved, That Resolution #4 of the Dallas-Guthrie County Medical Society (1973) not be adopted; and be it further

Resolved, That officials of involved county medical societies and physicians in charge of satellite medical clinics manned by physician's assistants be encouraged to confer as necessary to discuss any areas of disagreement in an effort to clarify misunderstandings and to resolve existing problems in a mutually satisfactory manner at the local level; and be it further

Resolved, That the IMS Committee on Delivery of Health Services, and/or other appropriate committees and officers of the IMS, as well as the State Board of Medical Examiners, be called upon, when necessary, to offer their guidance and counsel; and be it further

Resolved, That the IMS, through appropriate officers and committees, continue to be alert to the various activities, studies and philosophies dealing with the functions and responsibilities of the nurse and the physician's assistant in patient care, so that the medical profession can remain active in providing guidance and leadership as to the future roles of these two important ancillary professions to medicine; and be it further

Resolved, That the IMS reaffirm the traditional and necessary role of the physician as the captain of the

health care team.

Mr. Speaker, I move the adoption of the foregoing resolutions.

#### SUPPLEMENTAL REPORT OF COMMITTEE ON HEALTH CARE IN CORRECTIONAL INSTITUTIONS

The Reference Committee commends the Committee on Health Care in Correctional Institutions for its valuable and comprehensive report outlining its activities in obtaining information and evaluating the medical facilities and services at the four state-operated correctional institutions in Iowa.

RECOMMENDATION: The Reference Committee recommends that the following resolutions be adopted:

Resolved, That the Iowa Medical Society encourage institutions to utilize private physicians or clinic groups, with the apparent logical and desirable approach in Iowa being that of a contractural arrangement to provide parttime services (except at the Oakdale facility); and be it further

Resolved. That the Iowa Medical Society support a remuneration program for medical services in correctional facilities which is sufficient to attract well qualified physicians; and be it further

Resolved, That the Iowa Medical Society urge assignment of responsibility for the development and supervision of the health services program in a correctional institution to a medical director (even though he may be in a part-time capacity). This program should include a plan for care for each inmate to include an initial physical examination with annual re-examinations. Examinations should include appropriate laboratory and x-ray studies. Preventive health care should include indicated immunizations and vaccinations, as well as dental attention. Psychiatric studies should be made whenever necessary. An ongoing health education program should be implemented. The director of medical services should have a job description setting forth his responsibility and accountability; and be it further

Resolved, That the Iowa Medical Society urge the state institutions to find mechanisms to provide professional liability coverage for all physicians involved in the health care of the inmate population. Included in this should be the consideration of legislation to make the state the defendant in any liability action against the physician; and be it further

Resolved, That the Iowa Medical Society encourage the state institutions to explore the possibility of initiating formal training programs in paramedical fields, e.g., LPNs, Nurses aides, etc., for interested inmates; and be it further

Resolved, That the Iowa Medical Society suggest that the unit dose system for dispensing pharmaceuticals be established in all four facilities; and be it further

Resolved, That the Iowa Medical Society recommend the institutions assure the availability of consultation from the various specialty areas of medicine, and that this be accomplished with an eye toward cost containment, but without jeopardizing the factors of safety,

quality, etc.; and be it further

Resolved, That the Iowa Medical Society urge each institution to maintain a specific health care budget and endeavor to assure maximum utilization of the funding to provide quality services. Personnel, facilities and equipment should all be considered in the budgeting process; and be it further

Resolved, That the Iowa Medical Society commend the state officials involved in this important work for their good efforts and assure them of the desire of the medical profession to provide advice and counsel as possible; and

be it further

Resolved, That the Iowa Medical Society consider the continuation of this or a similar committee to assess and report on health care provisions in city and county jails in Iowa. It is believed that county medical societies could provide valuable support to a state committee in an evaluation of this type.

Mr. Speaker, I move the adoption of the foregoing

resolutions.

# RESOLUTION NO. 3—INTRODUCED BY POLK COUNTY MEDICAL SOCIETY HANDLING OF SUPPLEMENTAL REPORTS

"Resolved, That other than the Presidential Address, supplemental reports and other remarks be presented in written form prior to the convening of the House of Delegates, and mailed (to the delegates) ten days prior to the convening date."

RECOMMENDATION: The Reference Committee recommends the adoption of this resolution.

Mr. Speaker, I move the adoption of this resolution.

The Reference Committee wishes to note that although it is hoped the reading of supplemental reports can be kept to a minimum in an effort to reduce the length of opening sessions of the House of Delegates, the adoption of the above resolution does not preclude a report from being read if it is deemed sufficiently important to do so.

# RESOLUTION NO. 15—INTRODUCED BY POLK COUNTY MEDICAL SOCIETY HOUSE OF DELEGATES SCHEDULE

"Resolved, That future House of Delegates meetings not already contracted for, be held on Friday afternoon, Saturday, and Sunday with the first meeting of the House on Friday afternoon; Reference Committees on Saturday, and the second session of the House of Delegates on Sunday."

RECOMMENDATION: The Reference Committee recommends that the following resolution be adopted:

Resolved, That Resolution No. 15 be not adopted.

Mr. Speaker, I move the adoption of this resolution.

RECOMMENDATION: The Reference Committee recommends the adoption of the following substitute resolution:

Resolved, That the next meeting of the House of Delegates, be it "regular" or "annual" be arranged on a two-day schedule, if possible, at the discretion of the Board of Trustees, beginning with the opening session of the House on a morning, followed by reference committee hearings immediately following adjournment of the first session; and the final session of the House scheduled on the next day; and that officers of the Society poll the delegates and determine which days of the week would be most acceptable.

Mr. Speaker, I move the adoption of this resolution, as amended.

The Resolved was amended by deleting the words Saturday and Sunday and adding "if possible, at the discretion of the Board of Trustees," after the words, "two-day schedule," and further amended at conclusion of Resolved to read, "and that officers of the Society poll the delegates and determine which days of the week would be most acceptable." An informal poll showed a preference for Saturday and Sunday scheduling.

The Reference Committee is of the opinion that if the above schedule proves to be workable and convenient, it should be continued for future meetings.

# RESOLUTION NO. 16—INTRODUCED BY A. W. BOONE, M.D., DELEGATE, SCOTT COUNTY RECERTIFICATION EXAMINATION

"Resolved, That the IMS Delegates to the AMA be instructed to introduce a resolution requesting that the AMA Council on Medical Education study the above factors with regard to recertification and report back to the House of Delegates."

RECOMMENDATION: The Reference Committee recommends that in order to clarify the important intent of the above resolution, the following substitute resolution

be adopted:

Resolved, That the IMS Delegates to the AMA be instructed to introduce a resolution requesting that the AMA Council on Medical Education study (a) questions regarding the validity of cognitive type examinations with regard to the measurement of physician performance; (b) the implications of recertification examinations on medical practice; (c) the results of programs requiring documentation of continuing medical education; and (d) the periodic local measurement of a physician's performance as opposed to a requirement for a recertifying examination; and be it further

Resolved, That the Iowa Legislature be informed that the Iowa Medical Society is concerned about recertification and its implications, and has requested its delegates to the AMA to present this subject to the AMA for dis-

cussion and consideration.

Mr. Speaker, I move the adoption of the foregoing resolutions.

#### SUPPLEMENTAL REPORT OF COMMITTEE ON DRUG ABUSE

RECOMMENDATION: The Reference Committee recommends the adoption of the following resolutions:

Resolved, That the IMS Committee on Drug Abuse be authorized to investigate the feasibility of implementing a survey to collect data regarding the drug prescribing practices of physicians, and be it further

Resolved, That the Committee on Drug Abuse give specific attention to the costs of conducting such a study, the mechanics to be used in implementing it, and obtaining assurances to retain the data under the control of the Iowa Medical Society for use under their specific authority, and be it further

Resolved, That if such a study is considered to be feasible and beneficial, that based on its results, an educational program be developed for physicians which would be designed to alleviate problem areas with respect to drug prescribing practices, and be it finally Resolved, That the IMS Drug Abuse Committee be

Resolved, That the IMS Drug Abuse Committee be directed to report to the House of Delegates regarding the feasibility and propriety of conducting the proposed study and implementing a follow-up educational program if deemed necessary so that the House of Delegates can give final approval or disapproval to the recommendations of the committee.

Mr. Speaker, I move the adoption of the foregoing resolutions, as amended.

The last Resolved was amended to direct recommenda-

tions of Drug Abuse Committee to House of Delegates rather than Executive Council.

The Reference Committee expresses appreciation to the many members who presented their viewpoints during the reference committee hearings.

Respectfully submitted,
D. J. Soll, M.D., Chairman
R. E. Hedican, Jr., M.D.
C. T. Helseth, M.D.
K. J. Judiesch, M.D.

T. J. McIntosh, M.D.

1. J. MCINTOSH, M.D.

#### LEGISLATION AND MEDICAL SERVICE

The Reference Committee on Legislation and Medical Service met at 8:30 a.m. on Sunday, May 12, 1974. There was thorough and detailed debate on all the reports and resolutions. Those in attendance are to be complimented on the deliberations and the excellent manner in which the items were considered.

# SUPPLEMENTAL PROGRESS REPORT OF COMMITTEE ON ALTERNATE DELIVERY SYSTEMS

This report requires no specific action by the House of Delegates. The Reference Committee believes that the Committee is carrying out the functions assigned to it and will continue to keep the IMS informed on activities relating to alternate delivery systems.

RECOMMENDATION: Resolved, That the Supplemental Progress Report of Committee on Alternate Delivery

Systems be received as information.

Mr. Speaker, I move the adoption of the foregoing resolution.

# SUPPLEMENTAL REPORT OF THE IMS COMMITTEE ON EYE CARE

This report is again primarily for the information of the House and contains no specific recommendations.

RECOMMENDATION: Resolved, That the Supplemental Report of the IMS Committee on Eye Care be received as information.

Mr. Speaker, I move the adoption of the foregoing resolution.

#### RESOLUTION NO. 2—INTRODUCED BY POLK COUNTY MEDICAL SOCIETY AVAILABILITY OF THIRD PARTY FEE GUIDES

Discussion on the availability of third party fee guides appeared to fall into two general categories. Many physicians take the position that third party fee guides should be widely available to physicians to assure accuracy of fee information and to aid physicians in determining how their charges relate to that of other physicians. Some physicians believe that wide distribution of third party fee profiles could well result in a tendency for all fees to be fixed at an inflexible fee ceiling. The Reference Committee, in reviewing past IMS House of Delegates action, took note that 1) the House of Delegates asked that Relative Value Schedules with listed units for each procedure not be published or endorsed by the Iowa Medical Society, but that physicians determine their own usual charges, and 2) the House of Delegates has discouraged the distribution of fee data to protect against the establishment of inflexible fee ceilings, not responsive to changing circumstances in order to preserve the concept of individual and customary fees.

The Reference Committee is well aware of the many ramifications involved in the publication of fee information on a wide basis. The Iowa Foundation for Medical Care, as the Society's recommended peer review organization, does have available to it the detailed fee information referred to in the resolution. This information is utilized by the Foundation in reviewing cases referred to it by third parties and by physicians. Physicians should be encouraged to turn to the Iowa Foundation for Medical Care when questions arise regarding usual and customary fees. A majority of the Committee recommends that the following resolution be substituted for Resolution No. 2:

RECOMMENDATION: Resolved, That the Iowa Medical Society continue to endorse the usual, customary and reasonable fee concept and be it further

Resolved, That individual physicians be permitted to obtain their own "usual" fee profiles from Blue Shield and/or the Iowa Foundation for Medical Care; and be it further

Resolved, That physicians turn to the Iowa Foundation for Medical Care when disputes arise regarding third party payments.

On the recommendation of Dr. M. H. Dubansky, Polk County delegate, the original Reference Committee Report was revised to include the following portions of Polk County Resolution No. 2.

Resolved, That the Iowa Medical Society require Blue Shield and request private insurance companies to release to county medical societies, the Iowa Foundation for Medical Care, and individual doctors the customary fee screens or Relative Value Schedule including the dollar amount per unit used under health coverage programs; and be it further

Resolved, That the Iowa Medical Society take the necessary steps in order to obtain the cooperation of all third parties in making this information available.

Mr. Speaker, I move adoption of the foregoing substitute resolutions.

#### RESOLUTION NO. 4—INTRODUCED BY DICKINSON COUNTY MEDICAL SOCIETY SUPPLYING OF FEE DATA

The Reference Committee was informed that all Medicare fee data on a regional basis are already available and can be provided to individual physicians by the Medicare carrier. The intent of Resolution No. 4 has already been met by existing Medicare regulations and therefore, requires no formal endorsement.

RECOMMENDATION: Resolved, That Resolution No. 4 be not adopted.

Mr. Speaker, I move the adoption of the foregoing resolution.

#### RESOLUTION NO. 7—INTRODUCED BY DUBUQUE COUNTY MEDICAL SOCIETY PEER REVIEW BY SPECIALTY

Officers of the Iowa Foundation for Medical Care reported that under the existing peer review system, cases are formally reviewed at the first level by a physician of the same specialty and when additional consideration is required, the entire peer review committee involving other specialties joins in the consideration. The Reference Committee feels this procedure provides appropriate professional review with adequate input by individual specialties. The Reference Committee feels the following substitute resolution is more appropriate in lieu of Resolution No. 7:

RECOMMENDATION: Resolved, That the Peer Review Program performed by the Iowa Foundation for Medical Care which involves both specialty review and review by other physicians be continued.

Mr. Speaker, I move the adoption of the foregoing resolution.

# RESOLUTION NO. 11—INTRODUCED BY WEBSTER COUNTY MEDICAL SOCIETY THIRD PARTY RESPONSIBILITY

Discussion of Resolution No. 11 revealed that many of the existing hospital medical staff utilization review programs contain procedures involving "patient care coordinators" and similar lay staff functions to relieve the physician of burdensome administrative duties, but at the same time retain final authority with the profession. Several different approaches to accomplish the same goal are available and officers of the Iowa Foundation for Medical Care stand ready to assist hospital medical staffs in implementing appropriate review programs properly utilizing both lay and professional capabilities.

RECOMMENDATION: The Reference Committee suggests that the following substitute resolution be adopted in lieu of Resolution No. 1:

Resolved, That individual physicians and hospital medical staffs be encouraged to call upon the services of the Iowa Foundation for Medical Care in determining ways to conduct quality assurance programs which maximize the use of lay personnel for appropriate tasks while retaining the ultimate responsible role of the physician.

# RESOLUTION NO. 12—INTRODUCED BY WEBSTER COUNTY MEDICAL SOCIETY SUPPORT OF COUNTY SOCIETIES IN THIRD PARTY ACTIVITIES

Discussion before the Reference Committee demonstrates that the Iowa Medical Society and the Iowa Foundation for Medical Care devote considerable time and effort in representing the physicians' interests in relation to all third party programs both public and private. The Reference Committee acknowledges that many physicians are not aware of the services provided both by the Iowa Medical Society and the Iowa Foundation for Medical Care in the physician's behalf, even though both organizations have attempted through various means to inform the physicians as to what services are available.

RECOMMENDATION: The Reference Committee recommends that the following substitute resolution be adopted in lieu of Resolution No. 12:

Resolved, That the Iowa Medical Society and the Iowa Foundation for Medical Care continue to bring to the attention of Iowa physicians through written communication and personal contacts the services which both organizations can perform on behalf of physicians in their relationships with third parties.

Mr. Speaker, I move adoption of the foregoing substitute resolution.

# RESOLUTION NO. 9—INTRODUCED BY DUBUQUE COUNTY MEDICAL SOCIETY PRECERTIFICATION OF HOSPITAL ADMISSIONS

The Reference Committee is aware that in some areas of the country, hospital medical staffs have already instituted precertification programs on a voluntary basis. The Reference Committee is also aware that the federal mandate of such programs as recently attempted through Medicare and Medicaid is unacceptable. The efforts of the Iowa Medical Society and the AMA to prevent the implementation of "mandatory precertification" under Medicare and Medicaid have so far been successful in suspending implementation of these proposed regulations. The Reference Committee, therefore, recommends a minor change in Resolution No. 9.

RECOMMENDATION: Resolved, That federal regulations requiring mandatory precertification of hospitals admissions continue to be opposed vigorously.

Mr. Speaker, I move adoption of the foregoing resolution.

# RESOLUTION NO. 10—INTRODUCED BY WEBSTER COUNTY MEDICAL SOCIETY APPLICATION OF REGULATORY MEASURES

The Reference Committee agrees with the concept that government-operated hospitals, including the Veterans Administration, should implement appropriate programs of quality review as private hospitals are also undertaking these programs. The Reference Committee was informed that the American Medical Association has, on many occasions, adopted policy pronouncements requesting that government-operated hospitals be subject to the same quality review as private hospitals. The Reference Committee also noted that one of the proposed AMA amendments to the PSRO law is a provision to implement PSRO review of federal services such as Veterans Administration and Public Health Service. The Reference Committee, therefore, recommends a substitute resolution in lieu of Resolution No. 10.

RECOMMENDATION: Resolved, That the Iowa Medical Society delegates to the AMA continue to support all efforts which would require government-operated hospitals including the Veterans Administration, to implement programs of peer review similar to those required for private hospitals.

Mr. Speaker, I move adpotion of the foregoing resolution.

# RESOLUTION NO. 1—INTRODUCED BY DES MOINES-LOUISA COUNTY MEDICAL SOCIETY PSRO REPEAL AND PEER REVIEW

# NO. 13—INTRODUCED BY WRIGHT COUNTY MEDICAL SOCIETY SUPPORT FOUNDATION AS IOWA PSRO

# NO. 14—INTRODUCED BY KURT HAHN, M.D., DELEGATE, DES MOINES-LOUISA COUNTY MEDICAL SOCIETY PSRO

The subject most thoroughly discussed at the Reference Committee hearing involved the several aspects of Professional Standards Review Organizations. This obviously complex issue involves political realities, basic conviction of principles and the most appropriate response for professionals to these various factors. Past actions of this House of Delegates encouraging the Iowa Foundation for Medical Care to undertake appropriate steps to meet all contingencies as the physician peer review mechanism for Iowa were discussed. The subject is extremely complex, and requires careful and thoughtful evaluation. The Reference Committee took very seriously the comments at the open hearing and considered in some detail the posture of the IMS and the AMA in relation to PSRO. Physicians are keenly aware of the already existing requirements relating to utilization review under both Medicare and Medicaid and acknowledge the considerations now being discussed in Congress relating to such topics as National Health Insurance and additional programs of quality review similar to PSRO. In discussing PSRO, the Reference Committee has reviewed the approximately 20 amendments which the American Medical Association has offered to the PSRO legislation, including such items as 1) Authorization for non-professional PSROs postponed to 1978; 2) Norms to be developed by individual PSROs, to be guides only; 3) Preadmission certification only with consent of PSRO membership; 4) Deletion of financial sanctions for failure to comply with PSRO "obligation"; 5) Protection of confidentiality of PSRO against civil action; and 6) Provision of PSRO review of Federal services, such as VA, PHS. The Reference Committee believes that an appropriate response for this House of Delegates requires that some of the issues detailed in the three resolutions be considered independent of others. The Reference Committee, therefore, recommends the following resolutions in lieu of Resolutions 1, 13 and 14:

RECOMMENDATION: Resolved, That the Iowa Medical Society reaffirm its firm commitment to peer review under professional direction, and be it further

Resolved, That county medical societies and hospital medical staff peer review programs presently proven effective be retained; and be it further

Resolved, That the Iowa Foundation for Medical Care, as the physicians' professional peer review organization, be encouraged to continue to take all appropriate steps to enable it to meet in a responsible and professional manner any contingency relating to PSRO or other quality assurance programs.

Mr. Speaker, I move adoption of the foregoing resolu-

It is recognized by the Reference Committee that amending a law which is not yet implemented will be difficult and to repeal a law not yet implemented is probably impossible. The Reference Committee recommends adoption of the following resolution.

RECOMMENDATION: Resolved, That the Iowa Medical Society delegates to the AMA be instructed to represent the Iowa Medical Society in a constructive and progressive manner as it relates to PSRO at the AMA meeting in Chicago in June 1974, and be it further

Resolved, That the Iowa Medical Society and the American Medical Association continue efforts to exert leadership and to support constructive amendments to the

Mr. Speaker, I move adoption of the foregoing resolution. Mr. Speaker, this concludes the Report of the Reference Committee on Legislation and Medical Service. Respectfully submitted,

P. M. SEEBOHM, M.D., Chairman

T. F. DYNES, M.D.

J. H. Lohnes, M.D.

R. M. Powell, M.D.

R. C. SMITH, M.D.

Dr. Caraway expressed his appreciation for the manner in which the delegates participated at Reference Committee hearings. Dr. John Sunderbruch thanked the delegates for their support of the Iowa Foundation for Medical Care. The Speaker then asked if there was any new business to come before the House. Dr. Schlaser moved that the House of Delegates approve the action of the IMS Board of Trustees from the date of the last previous annual meeting. The motion, worded as follows, was seconded and adopted:

Resolved, That the action of the Board of Trustees of the Iowa Medical Society from the date of the last annual meeting to the present be and hereby are ratified

and confirmed.

Dr. Schlaser gratefully acknowledged the pleasant association enjoyed by the officers of the Society with IMS President, Dr. Rubin Flocks, during the past year and the

House responded with standing applause.

Dr. Caraway announced organizational meetings of the Board of Trustees and Judicial Council would be held immediately following the adjournment of the House of Delegates and inaugural remarks by Dr. Wicks. Following his installation as new IMS President, Dr. R. L. Wicks addressed the House briefly. His remarks are published on page 269 of this issue of the JOURNAL. The House of Delegates was adjourned at 11:30 a.m.

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# **INDEX**

290
Articles of Incorporation and By-laws, Reference Committee Report, 323
Articles of Incorporation and By-Laws, Report of Standing Committee, 281
Articles of Incorporation and By-Laws, Supplemental Report of Standing Committee on, 311, 323
Associate memberships, 321 Associate memberships, 321 Attendance of Delegates, 277 Availability of Third Party Fee Guides, Polk County Medical Society resolution, 319, 327 Blood Banking, Committee on, 290 Blue Cross/Blue Shield, alcoholism project, Blue Cross/Blue Shield, coverage for psy-chiatric care, 288 Blue Cross/Blue Shield, HMO involvement, 294, 318 Blue Cross/Blue Shield, IMS group cover-Blue Cross/Blue Shield, IMS group coverage, 293
Blue Shield Report to Iowa Medical Society House of Delegates, 303ff
Board of Trustees, 278, 281
Board of Trustees, Reference Committee Report of, 323
Board of Trustees, Supplemental Report, 300ff, 323, 324, 325
Boone, A. W., M.D., Recertification Examination Resolution, 321, 326 Cancer Epidemiologic Research Center, 296-297 CHAMPUS, 284, 303 CHAMPUS, 284, 303 Chiropractic, 282, 286, 298, 311 Claim form, universal type, 284 College of Medicine, 289, 292, 296, 297, 306 Commissioner of Health, 287, 301 Communicable disease, 312-313, 324-325 Communications from IMS, 279 Community Emergency Medical Services, Committee on, 290-291 Compensation for IMS President, Linn County Medical Society resolution, 319-320, 323 320, 323
Comprehensive Health Planning, Office of, 291, 294-295, 296
Conferences, national, regional, state, 279
Continuing medical education, 282-283, 298
Cost of living regulations, 284
County medical society officers, 276
Current Procedural Terminology, 301, 304
Customary fee profiles, 304-305, 327 Death, definition of, 297 Delegates, listing of, 277, 322 Delegation of Authority, Committee on, 291
Delivery of Health Services, Committee on, 291-292, 325
Delivery of Health Services, Supplemental report of Committee on, 313-314, 325
Des Moincs-Louisa County Medical Society resolution, PSRO Repeal and Peer Review, 319, 328
Dickinson County Medical Society resolution. Supplying of fee data, 319, 327
Drug Abuse, Committee on, 292-293
Drug Abuse, Supplemental report of Committee on, 314-315, 326-327
Dubuque County Medical Society resolution, Honorary Membership in IMS, 320, 324 324
Dubuque County Medical Society resolution, Peer Review by Specialty, 320, 327
Dubuque County Medical Society resolution, Precertification of Hospital Admissions, 320, 328
Dues for 1975, 302, 324

Aging and Chronic Illness, Subcommittee on, 287

on, 284 Alcoholism, Committee on, 289-290 Alternate Delivery Systems, Supplemental report of Committee on, 318, 327 AMA/CPT, 301, 304 AMA-ERF, 299 Antisubstitution laws, oppose repeal of,

286 Antisubstitution proposal defeated, 311 Application of Regulatory Measures, Webster County Medical Society resolution, 320, 328

Architectural Education, Committee on,

Dues for members starting practice, 302, 311, 323-324 Dues for members, student medical society, 302, 311, 323, 324Eckstein, John W., M.D., 306 Economics of Health Care, Committee on, Emergency medical services, 290-291, 292 Executive Council, 278 Eye Care, Committee on, 293, 327 Eye Care, Supplemental report of Committee on, 315, 327 Family nurse practitioner, 301 Family planning, 287 Family practice residency programs, 292, \_\_296 296
Fee guides, availability of, 319, 327
Field service, 279
Fifty Year Club members, 265
Film on medical care delivery, 301
Films, requests for, 281
Financial statement, 280-281
Financial status of IMS, 300 Grievance Committee, 281 Group Insurance, Committee on, 293-294 Hahn, Kurt, M.D., PSRO-IMF resolution, 321, 328 Handling of Supplemental Reports, Polk County Medical Society resolution, 319, 326 Hawkeye Science Fair, 285
Health Care in Correctional Institutions,
Committee on, 294
Health Care in Correctional Institutions,
Supplemental report of Committee on,
315ff, 325-326
Health Education, Committee on, 281-282
Health insurance claim form, 284
Health maintaneae organizations, 282, 284 Health maintenance organizations, 282, 284, 291, 294, 318
Health Maintenance Organizations, Committee on, 294
Health planning, 291-292, 294-295
Health Planning Programs, Committee on, 294-295 294-295 294-295 Historical Committee, 295 Honorary Memberships in IMS, Dubuque County Medical Society resolution, 320, 324 Hospital/medical staff relations, 301 House of Delegates, meeting schedule, 301, 326 House of Delegates, new apportionment, 281, 300

House of Delegates Schedule, Polk County
Medical Society resolution, 321, 326 Immunization, 287, 312-313, 324-325 IMS dues, 324 IMS representation, national level, 279 Independent Laboratories, Committee on, 295 Landustrial Health, Committee on, 295 Insurance Commissioner, 285, 311 Intermediate Care Facilities Program, 287 Interprocessional Activities, Subcommittee on, 286
Iowa Chapter, American Association of Medical Assistants, 296, 318
Iowa Foundation for Medical Care, report on, 302-303, 328-329 Iowa General Assembly, 283, 288, 295, 296, 298, 301, 311 Iowa Health Council, 285, 286 Iowa Hospital Association, 290, 301, 303 Iowa Medical Political Action Committee, Iowa Nurses' Association, 291, 301, 314 Iowa Pharmaceutical Association, 286 Iowa Regional Medical Program, 295, 301 Iowa State Department of Health, 284, 287, 290, 312-313, 325

Journal of the Iowa Medical Society, 279, 287, 289, 297 Judicial Council, Handbook report of, 281 Judicial Council, Supplemental report of, 308ff, 324

Laboratory proficiency program, 295 Legislation, Committee on, 282 Legislation, Supplemental Report of Committee on, 311

Legislation and Medical Service, Reference Committee on, 327ff
Leinbach, S. P., remarks of, 305-306
Licensing of professions, 282-283, 311
Life memberships, 321
Linn County Medical Society Resolution,
Compensation for IMS President, 319-320,

Malpractice insurance, 285, 311-312, 324 Maternal and Child Health, Subcommittee on, 287

Maternal and Child Health, Supplemental report of Subcommittee on, 312-313, 324-325

Maternal Mortality Committee, 287 MD/DO Liaison Committee, 295-296

M.D.-Nurse lialson, 301
MECO program, 298
Medicaid, 284, 287, 288, 293, 303
Medical Assistants Advisory Committee,

Medical Education and Hospitals, Committee on, 282 Medical Examiners, Board of, 282-283, 297,

Medical examiners, composition of board,

Medical Manpower, Committee on,

Medical Manpower, Committee on, 296
Medical Practice in Health Facilities and
Homes, Subcommittee on, 284
Medical Review, Subcommittee on, 284
Medical Service, Committee on, 284
Medicare, 284, 303, 327
Medicare, 284, 303, 327
Medico-Legal Committee, 285
Medico-Legal Committee, Supplemental report of, 311, 324
Medicredit, 282, 284
Membership, 279-280

National Emergency Medical Service, Committee on, 296 National health insurance, 282, 284

Necrology Committee, 282, 310 Nominating Committee, Supplemental report of, 310 Nursing, relation to, 291, 295, 301, 314, 325

Oncology, Committee on, 296-297 Organ Transplantation, Committee on, 297

Paramedical Services, Committee on, 297

Peer Review, 284
Peer Review by Specialty, Dubuque
County Medical Society resolution, 320,

Pharmacy, pilot project, 286 Physician's assistants, 292, 297, 301, 314, 325

Physicians' Assistants, Committee on, 297
Polk County Medical Society resolution,
Availability of Third Party Fee Guides,

319, 327 Polk County Medical Society Handling of Supplemental Reports, 319,

326 Polk County Medical Society resolution, House of Delegates Schedule, 321, 326 Preadmission testing, 304 Preceptorship Committee, 298 Precertification of Hospital Admissions, Dubrous County Medical Society resolution

buque County Medical Society resolution,

Problem-oriented medical record, 284 Professional liability insurance, 285, 311-

Professional liability insurance, 285, 311-312, 324
Prouty Company, group insurance administrators, 293-294
PSRO, 284, 302-303, 328-329
PSRO-IMF, resolution by Kurt Hahn, M.D., delegate, Des Moines-Louisa County Medical Society, 321, 328
PSRO Repeal and Peer Review, Des Moines-Louisa County Medical Society resolution, 319, 328
Psychiatric Care, Subcommittee on, 288

Public Assistance, Subcommittee on, 288 Public health nursing, 285 Public Relations, Committee on, 285-286 Publications Committee, 289

Quackery, Committee on, 298
Qualifications for Election of District
Councilor, Wayne County Medical Society resolution, 319, 323

Recertification examination, Resolution by A. W. Boone, M.D., delegate, Scott County Medical Society, 321, 326 Rehabilitation, Subcommittee on, 289 Relicensure of physicians, 282-283 Reports of Officers, Handbook, 278 Reports of Officers and Miscellaneous Business, Reference Committee on, 324ff Reports of Special Committees, 289 Rural Health, Committee on, 298 Rural Medical Family Practice Units, 313-314, 325 314, 325

Safe Transportation, Subcommittee on, 289 Scanlon Medical Foundation/Iowa Medical Society, Informational report of, 307-308

308
Scientific Program, 277, 286, 296, 300
Scientific Work, Committee on, 286
Secretary, report from office of, 278
Speakers, requests for, 281
Sports Medicine, Committee on, 298-299
Standards of medical care, 284
State Departments, Committee on, 286-287
State Department of Social Services, 287, 288, 293 288, 293

Student Iowa Medical Society, 302, 308ff,

Student Loan Program, 307-308 Supplemental Reports, 300 Supplemental Reports, Handling of, Polk County Medical Society resolution, 319, 326

Supplemental reports, special committees, 313ff Supplemental reports, standing committees,

Supplemental Security Income Program,

288-289
Supplying of Fee Data, Dickinson County Medical Society resolution, 319, 327
Support of County Societies in Third Party

Activities, Webster County Medical Society resolution, 320, 328 Support Foundation as Iowa PSRO, Wright County Medical Society resolution, 320,

Termination of pregnancy, 287 Third Party Responsibility, Webster County Medical Society resolution, 320, 327-328 Treasurer's Report, Handbook, 280-281

Unified membership, county, state, AMA, 301

Usual, Customary and Reasonable (UCR) Program, 304

Voluntary Health Agencies, Committee on,

Wayne County Medical Society resolution, Qualifications for Election of District Councilor, 319, 323

Webster County Medical Society resolution, Application of Regulatory Measures, 320,

Webster County Medical Society resolution, Webster County Medical Society resolution, Third Party Responsibility, 320, 327-328 Webster County Medical Society resolution, Support of County Societies in Third Party Activities, 320, 328 Woman's Auxiliary Advisory Committee,

299-300

Wright County Medical Society resolution, Support Foundation as Iowa PSRO, 320,

# respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or

two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An h.s. dose added to the b.i.d. or t.i.d. treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, et al: Dis Nerv Syst 30:675-679, Oct 1969.

2. Hollister LE, et al: Arch Gen Psychiatry 24:273-278, Mar 1971. 3. Claghorn J: Psychosomatics 11:438-441, Sept-Oct 1970. Valium (diazepam) 2-mg, 5-mg, 10-mg tablets

> in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

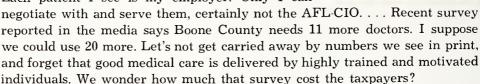
spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



# President's Page

Random notes from the memo pad—New partner arrives today. Well-trained, confident and eager to see first private patient. Fourth to join the group, arrival none too soon to suit others. They're all great.... The AMA delegates showed their muscle and changed some of the old guard. Iowa's Herman Smith was elected to AMA Council on Constitution & By-Laws. He'll represent us well. Our Iowa AMA delegates are most conscientious. They deserve our praise for their good efforts.... IMS staff arose at 4 a.m. to drive to Chicago AMA meeting. Practicing economy. These staff people are loyal and also deserve our praise. Your officers appreciate them, we hope that all of the membership does.

How could I benefit from union membership? Each patient I see is my employer. Only I can



The 1975 Scientific Program Committee is compiling a list of interesting subjects. Have topnotch speakers in mind, too. More about scientific program will be coming to all members soon. Dates are April 3 to 8.

Sincerely,

Ralph L. Wicks

Ralph L. Wicks, President

# (acetaminophen)



The patient with asthma or allergy



The patient with gastritis



The patient on uricosurics



The patient on anticoagulants



The peptic ulcer patient



The febrile. dehydrated child

Since there are so many, why not use TYLENOL® tablets and elixir routinely for pain or fever?

When one of the types of patients pictured above needs an analgesic.

you have another 'type for TYLENOL (acetaminophen)' a person who should avoid aspirin.

Considering their number, wouldn't it make sense—and provide an added margin of safety -to recommend TYLENOL (acetaminophen) to all the

patients in your practice who require an analgesic-antipyretic?

Precautions and Adverse Reactions:

If a rare sensitivity reaction occurs, the drug should be stopped.

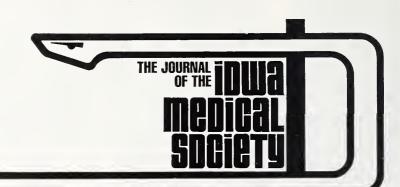
TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg. For Children:

Elixir, 120 mg./5 cc. (alcohol 7%). Drops, 60 mg./0.6 cc. (alcohol 7%). Chewable Tablets, 120 mg.

Safer than aspirin, yet just as effective for relief of pain and fever

(acetaminophen)



VOL. 64 No. 8 AUGUST, 1974

TABLE OF CONTENTS		SPECIAL DEPARTMENTS	
		President's Page	344
Methaqualone: An Irrational Hypnotic		Iowa Medical Miscellany	347
Dennis K. Helling, Pharm.D., and Kirk H.	351	State Department of Health .	348
Some Opportunities and Issues in Medicine		Educationally Speaking	364
Robert Q. Marston, M.D.	355	In the Public Interest	365
Pulmonary Endometriosis: Report of a Case Paul From, M.D., Harrison W. Pratt, II,		Medical Assistants	369
D.O., and Joseph Torruella, M.D.	360	About Iowa Physicians	370
		Deaths	371
EDITORIALS			
Eager Beaver Tendency	362	MISCELLANEOUS	
T.L.C.?	362	Page County Medical Society Annual Fall Scientific Meeting	363

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# **IOWA** Medical Miscellany

PSRO ACTION . . . Of AMA was reported in IMS News Bulletin 74-7. AMA House voted 184-57 in June to seek constructive amendments to PSRO program, particularly in potentially dangerous areas such as confidentiality, malpractice, development of norms, quality of care and HEW authority. House also directed AMA to continue efforts to achieve legislation which allows profession to perform peer review according to established medical philosophy. State associations rejecting PSRO were not precluded from doing so, they were urged to develop effective non-PSRO review programs. New AMA policy says if PSRO program does adversely affect patient care or conflict with AMA policy legal and legislative action should be taken to rectify situation.

NHI... On national health insurance, AMA House asked its Board of Trustees to cooperate with state associations "to attempt to devise mechanisms mutually acceptable to the private medical and insurance communities which will ensure the provision of health insurance coverage through the purchase of private health insurance, and to seek means to secure favorable Congressional and public support for adoption." The House urged effort to detach any NHI program from the controlling intrusions of existing PSRO laws and regulations.

IOWA RESOLUTION... Urging further study of ways of measuring physician performance was approved by the AMA House. Resolution requested AMA Council on Medical Education to continue evaluation of methods which might be used in physician recertification. The House approved a Board report on continuing medical education which affirmed its importance but urged delay of relicensure laws pending further study.

**GRANT APPROVED** . . . Application of the Iowa Foundation for Medical Care for a PSRO planning contract has been approved by HEW with a grant of \$45,500 provided.

ELECTED . . . Herman J. Smith, M.D., Des Moines, one of Iowa's AMA delegates, was elected in June to the AMA Council on Constitution and Bylaws. Douglas Hiza, M.D., recent U. of I. medical graduate, was elected intern-resident member of the AMA Council on Medical Service.

**MEETING...** IMS Committee on Medical Review met July 10 to consider several important topics, i.e., implementation of the statewide customary profile by specialty, availability of customary profiles, etc.

NEW ALCOHOLISM LAW . . . Went into effect July 1. Provisions of law say intoxicated person may be taken by authorized individuals (police or representatives of alcoholism service unit) to hospital, detox center, etc. Intoxicated person brought to such a facility must be examined by a licensed physician within 12 hours.

FNP PROGRAM . . . IMS is cooperating with Iowa Hospital Association in a pilot Family Nurse Practitioner project to train and place 6 FNP's in satellite clinics in rural Iowa. Nurse applications are now being screened. Training will be supervised by physician preceptors.

PA RULES...IMS representatives participated in a June meeting with Board of Medical Examiners to review proposed rules and regulations governing utilization of physicians' assistants in Iowa

**JULY CONFABS...** Meetings of the IMS Board of Trustees, Judicial Council and Executive Council occurred in Des Moines July 24 and 25.

# State Department of Health

# What Every Health Practitioner Should Know About Preventing Dental Disease

BERNARD L. LUTZ, D.D.S., M.P.H., Ph.D. and JOHN E. GOODRICH, D.D.S., M.P.H.

The following is a review of the more significant scientific literature on "plaque control" as it relates to the problems of oral health maintenance and dental disease prevention. The reader is encouraged to use the accompanying bibliography to add to his knowledge and to design programs to meet the dental disease problems of a practice, school or community.

#### A Strategy for Dental Disease Control

The accumulated evidence from empirical studies and clinical research in dental disease control indicates that dental "plaque" is the principal causative agent in both dental decay and periodontal disease. 1, 2, 16, 17, 32, 37 Naturally present bacteria from the oral cavity accumulate on the tooth surface in sufficient quantities to form a microcosm or bacterial colony. This colonization is aided by morphological characteristics such as the pits fissures on the occlusal surface of teeth. On smooth surfaces, certain types of bacteria are able to convert glycoproteins and carbohydrates to dextrans and levans which provide adher-

Current research indicates it is this mature plaque which presents the capacity to cause dental caries. Once the colony has organized, it may produce acid from sucrose very rapidly (within a few seconds) and raise the acid level at the plaque interface to a point where erosion and enamel dissolution results. Unorganized or immature plaque or microbial colonies lack the capacity to produce byproducts in sufficient quantities to cause significant destruction to tooth structure. It is believed the once-a-day thorough disorganization of the plaque is usually sufficient to stabilize the oral microbial colonies or population to the innocuous or non-pathogenic level.

Bacterial populations which are harbored in the gingival sulcus and at the gingival margin possess characteristics which produce irritation, inflammation and desquamation of tissue lining from the outer wall of the sulcus. This erosion of the epithelial lining often results in bleeding. Any plaque dispersion method to be effective must be designed to clean the sulcular area the full circumference of each tooth. 1, 2, 7, 32, 42

ence to tooth structure and protection from the buffering agents of saliva.<sup>15</sup> The bacterial composition of these initial colonies changes in time and it is this "maturity" which determines the relative pathogenicity of the microcosm. Inhabitants of the mature bacterial colony use sucrose and produce waste products which are highly acidic and destructive to the underlying tooth structure.

Dr. Lutz is an associate professor in the Division of Comprehensive Care in The University of Iowa College of Dentistry. Dr. Goodrich is director, Dental Health Division, and chief, General Health Service, State Department of Health, Des Moines, Iowa.

Bacterial accumulations and debris may occur in interdental spaces between the buccal and lingual papilla. If these papillae become inflamed, enlarged, or for other reasons interfere with effective interdental cleaning, they may be recontoured or surgically removed to facilitate access and cleaning as well as tissue health maintenance. 19, 38 Some periodontists are convinced that tissue contour is at least as important as sulcular brushing in maintaining orai health. 18 The important thing to keep in mind is that, with the exception of traumatic techniques, it is the thoroughness rather than the method which determines the effectiveness of the plaque control program. When the patient is limited in his desire or ability to remove plaque effectively, or when recurrent caries require augmentation of dental disease control measures, a complete diet analysis should be made to determine the pattern and frequency of fermentable carbohydrate exposure. A diet prescription may need to be included in the individual's disease control regimen.

Additional protection against dental decay will often include the use of fluorides. In areas where the drinking water is low in fluoride, or where the family's dental health history indicates a high rate of caries activity, topical and dietary fluorides, as well as fluoride dentifrices, should be prescribed. Children up to the age of two may receive fluoride supplement in the form of drops placed in the buccal space daily. At the age of two, the child may supplement topical applications of fluoride with a chewable tablet. Normal dosage is one tablet daily containing 1 mg of fluoride.

# Selection and Use of Aids in a Program of Plaque Control

The selection of a particular brushing and cleaning method will depend on a number of factors which need to be considered for each individual patient or group of people to whom instruction is being given.<sup>1, 6, 32</sup> Conditions affecting the choice of method will include the following:

- 1. The oral health status of the patient.
- 2. The objectives of the method and aids to be used.
- 3. The knowledge, attitudes, skill, and patience of the therapist or teacher.
- 4. The motivation and skill of the patient in using the methods and aids to be prescribed.

Although variations and individual adaptations will need to be prescribed for special needs, a

plaque dispersion program should generally have the following objectives:

- 1. At least once a day thorough cleaning of all surfaces of all teeth, including any fixed or removable appliances.
- 2. At least once a day cleaning of the sulcular areas, including the complete circumference of all teeth.
- 3. The removal of debris and microbial accumulations from the interdental spaces, exposed bifurcated areas, occlusal surfaces, and areas where there are abnormal gingival pockets.
  - 4. The mild stimulation of the gingival tissue.

This plaque dispersion method which comes closest to meeting these objectives is generally referred to as the sulcular cleaning or the Bass method. The reader is encouraged to secure a copy of a pamphlet produced by Zaki43 which explains in pictures the technique most frequently supported by plaque control educators. In this method, the brush is held parallel to the chewing surface of the teeth while the bristles are directed into the sulcus at a 45 degree angle to the long axis of the tooth or teeth being cleaned. Short vibratory strokes or motions are made in an anterior-posterior direction as the brush is slowly moved around the arch. Care is taken to use light pressure when directing the bristles into the sulcus. The gingival tissue in the area of the sulcus is also cleaned and stimulated during the sulcular brushing and, as much as possible, the bristles are also directed into the interdental space to clean as much of the interproximal area of each tooth as can be reached in this manner. More detailed directions can be found in the Zaki pamphlet.

After thorough brushing, the patient must use dental floss to clean the approximating surfaces, around bridges, and appliances, and areas generally not accessible to the brush. Each tooth surface is scraped clean by gently working the floss through the contact and into the interdental sulcus until resistance is reached. Thus, with the floss wrapped either mesially or distally as far as possible, the plaque is sheared from the tooth surface with firm pressure while bringing the floss toward the occlusal surface of the tooth. Once the patient develops sufficient dexterity, a single scrape of each surface is sufficient to disorganize the plaque microcosms such that the microbial ecosystem requires 24 hours to recover to a destructive level of pathogenicity. During initial training, the patient will need a mirror and

(Please turn to page 366)

# alone together...

have left the phone and stock quotations with the Trust Department of your lowa bank and spent your day off really relaxing with your hobby or family. It frequently happens, though, that as a busy professional person you must use your spare time to study, investigate and analyze the facts about investments when you are trying to manage the job yourself. An lowa Trust Department could give you back your spare time if you were to turn the task over to them. Studying, investigating and analyzing investments of all kinds is their business. They

have a continual flow of accurate investment data on which to base sound decisions . . . tailored to the professional person's financial needs. With a Living Trust or Investment Management Account all the details of a wise investment program are handled for you by our skilled and experienced professionals. We can give you the time to face more important free time decisions: a spinner or a jig...a five or seven iron...dinner and dancing or a movie...softball or football with the kids...And our fee is deductible, so you see Iowa Trust Departments can save you time and money.





# Methaqualone: An Irrational Hypnotic

DENNIS K. HELLING, Pharm.D., and KIRK H. STRONG, M.D.

SLEEP-INDUCING DRUGS, referred to as hypnotic or soporific drugs, are among the most widely used in clinical medicine. Jick and colleagues1 and Shapiro and associates<sup>2</sup> reported from their surveys that insomnia is the second most common indication for drug intervention. Nearly half of the patients in these series were treated with a hypnotic drug. Another survey of patients hospitalized with acute myocardial infarction showed that nearly 80% received hypnotic medications, most of which were short-acting barbiturates.3 Hypnotics are likewise in wide use among ambulatory patients. Nonproprietary sleeping medications account for more than 50 million prescriptions yearly,4 and countless more proprietary or over-the-counter hypnotics are sold without prescription.

Occasional insomnia is probably universal in adults, and chronic insomnia is one of the most frequent complaints, especially in the aged and in patients with various physical, psychological and psychiatric disorders. The different patterns of sleep disturbance are of clinical importance in

Concern is expressed regarding the use of methaqualone. It is noted as the third most commonly prescribed non barbiturate hypnotic in the country. The authors present several reasons for questioning its wide use.

choosing the treatment for this highly individualized condition. "Insomnia may be associated with many physical or emotional disorders, but is more likely a consequence than a cause." In many patients, insomnia may respond optimally to an understanding, reassuring physician and will not require drugs or psychiatric intervention. <sup>5</sup>

Many therapeutic approaches other than drug therapy are available to manage insomnia. Drugs, however, appear to constitute one of the most prevalent methods of treatment, as sedative-hypnotic drugs rank high among pharmaceuticals manufactured and prescribed. A significant proportion of hypnotic drug use is of the self-medication variety, i.e., a large number of over-thecounter sleeping medications are available without a prescription. These hypnotics are usually combination products, containing scopolamine and an antihistamine such as methapyrilene, both of which possess sedative properties in small doses. Although some patients find these overthe-counter products helpful in inducing sleep, controlled study has shown them to be no more effective than placebo in hypnotic efficacy. 6 Over-

Dr. Helling is an assistant professor of clinical pharmacy at The University of Iowa College of Pharmacy and clinical pharmacist at the Oakdale Family Practice Office. Dr. Strong is a family physician in Fairfield, Iowa, and is a member of the Drug Abuse Committee of the Iowa Medical Society.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF AUGUST, 1974

dosage or poisoning with nonprescription sleeping medications, whether in suicidal attempts or for hallucinogenic purposes, is becoming an increasingly significant problem and usually presents a clinical picture of acute toxic psychosis.

#### PRESCRIPTION HYPNOTICS

Prescription hypnotics have been shown to be consistently more effective than placebo in producing sleep. Contrary to numerous manufacturer's claims of individual hypnotic superiority, there is substantial evidence from controlled trials that little difference exists in the sleep-inducing efficacy of the various prescription hypnotics. Furthermore, side effects associated with therapeutic doses of most hypnotic drugs are not usually of great concern clinically and occur with nearly equal frequency among the various agents.<sup>5</sup>

Lacking consistently demonstrated differences in efficacy or toxicity among therapeutic doses, the clinician before choosing a hypnotic drug should consider the following factors: (1) The perfect all-purpose hypnotic does not yet exist. (2) The ideal hypnotic would provide rapid onset and sufficient duration of sleep. (3) It would lack adverse side effects, be non-habituating and carry a wide margin of safety. (4) It would not produce morning hangover or disrupt the EEG patterns of normal sleep.

EEG activity during normal sleep has been classified into five stages, the REM, or rapid-eyemovement, and four non-REM periods (stages 1 to 4). In non-REM sleep, from stages 1 through 4, muscles become progressively more relaxed, blood pressure, temperature and heart rate decline, breathing becomes slow and regular, there is a progressive slowing and increased amplitude in the EEG, and the person becomes harder and harder to awaken. Stage 4 appears to be the time when a person is most "deeply" asleep. The sleep cycle (for normal young adults) consists initially of 70 100 minutes of non-REM sleep before the first period of REM sleep begins. Thereafter, REM periods occur cyclically about every 90 minutes throughout the night and occupy 20-25% of the total sleep time. During REM sleep, there are intermittent bursts of eve movements, a marked decrease in muscle tone, and a low amplitude, fast frequency EEG. Althought it may be extremely difficult to awaken a person at this time, his brain activity paradoxically resembles waking (hence the term paradoxical sleep).

#### DREAMING

To call REM sleep "dreaming sleep" may be misleading because dreaming and dream-like experiences occur in all phases of sleep. In general, however, REM sleep seems to be a time of most vivid, visual dream experience and normal periods of REM sleep appear to be desirable. The nightly percentage of REM sleep varies only slightly among children, young adults, and the elderly, but total sleep time and Stage 4 are considerably decreased in the elderly.

Methaqualone (Quaalude®—Rorer) is the third most commonly prescribed nonbarbiturate hypnotic in the United States today.<sup>7</sup> It is also available in the United States as Sopor® (Arnar Stone), Parest® (Parke Davis), Somnafac® (Cooper), and Optimil® (Wallace). Methaqualone has rapidly gained unprecedented popularity on the American drug scene. Recent writers have described changing drug abuse patterns, with an increase in the use of depressants in the face of a leveling off of heroin and stimulant abuse.<sup>8, 9</sup> The abuse of methaqualone as a "downer" or "sopor" has increased to the proportions of a silent epidemic.<sup>10</sup>

The major promotional features of methaqualone are that it is alleged to be a nonbarbiturate, nonaddicting sedative-hypnotic, which produces but minor suppression of REM sleep with little or no rebound increase in REM sleep when it is withdrawn, and no initial excitation phase such as is often seen with other sedativehypnotics. 11-13 In short, it has been suggested that methaqualone is a hypnotic drug with all the advantages and no disadvantages. 11 The Medical Letter on Drugs and Therapeutics11, 12 has consistently warned the medical profession to be wary of the validity of these promotional claims. The well recognized studies by A. Kales, et al. 14, 15 dispute the advertising claims concerning REMsleep suppression; methaqualone in the usual hypnotic dose of 300 mg produces a significant suppression of REM sleep time with a pronounced rebound increase in REM time after drug withdrawal. In this respect, 300 mg of methaqualone did not differ markedly from equivalent doses of other hypnotic drugs, such as glutethimide (Doriden®) 500 mg, methyprylon (Noludar®) 300 mg, and the barbiturates, secobarbital sodium (Seconal®) 100 mg and pentobarbital sodium (Nembutal®) 100 mg.

#### NO HARD EVIDENCE

There is no convincing evidence to support the manufacturer's claim that Quaalude®, unlike other sleep medications, causes little or no "post-hypnotic CNS depression or hangover." Additional side effects include transient acroparesthesia, epistaxis, dizziness, urticaria, mental disturbances, thick and dry tongue, depersonalization, constipation and cracking at the angles of the mouth. Some evidence of teratogenicity in rats has been reported and the drug is therefore, to be avoided in pregnancy. Also, there are poorly documented cases of aplastic anemia and agranulocytosis related to methaqualone use. 13, 17

Despite the manufacturer's claim that "psychological dependence has occasionally occurred with methaqualone" and that "physical dependence has rarely been reported," caution is urged "in administering methaqualone to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative."13 Although initially methaqualone was thought to be without dependence producing capability, reports of dependence and barbiturate-alcohol type withdrawal symptoms have flooded the world literature. 12, 18, 19 Clearcut dose duration correlation for physiological addition to methaqualone has been difficult to establish. Many of the reported cases of addiction involved a dose of 1.5 to 3 gm for about two months. However, even with semi-regular use, prodromal symptoms of true physiological addiction can occur,19 Withdrawal symptoms most frequently seen are those of headache, anorexia, nausea, abdominal cramps, delirium tremens, and disturbed sleep patterns.

As a "downer," methaqualone appears to have an inordinate capacity to produce a dissociative "high" and ultimately a compelling dependence. Users describe a loss of physical and mental self. In some areas the drug has replaced marihuana. It also carries the mythical reputation of an aphrodisiac and is often called "the love drug." Depressant drugs may lower inhibitions in the sexual attitudes of some individuals, and this should not be considered a unique property of methaqualone alone. In fact, with increasing doses of depressants an actual loss of libido will be seen.

#### ACUTE INTOXICATION

Acute intoxication with methaqualone (i.e., either accidental or suicidal) has been increasing.

Two hundred seventy-five cases were reported in 1972, with 16 of them resulting in death.<sup>20</sup> Single doses ranging from 8 to 20 gm have produced severe toxicity and death. Methaqualone poisoning is characterized by coma, marked hypertonia, and tonic convulsions. Respiratory depression and arrest do occur, especially when methaqualone is combined with other depressant drugs such as alcohol. Because of methaqualone's high potential for abuse and relatively limited usefulness in medicine, the Drug Enforcement Agency (DEA) has placed this drug in Schedule II of controlled substances (the same class as narcotics and shortacting barbiturates), which provides for written prescriptions only and for unrefillable prescriptions.

On the other hand, 30 mg of flurazepam (Dalmane®) and 500 and 1000 mg doses of chloral hydrate did not significantly alter REM sleep, nor were they followed by REM rebound on with-drawal.  $^{14.15}$ 

Although the toxic-to-therapeutic ratio of chloral hydrate resembles that of the barbiturates, overdose with this agent is infrequently reported. Chloral hydrate does not alter REM sleep and is a relatively safe, rapidly effective and reliable sedative-hypnotic.<sup>21</sup> There is little experience with this drug in pregnant women and its safety for the fetus has not been established. The interaction of chloral hydrate with oral anticoagulants is controversial. It has been demonstrated that trichloroacetic acid, the major metabolite of chloral hydrate, displaces warfarin from binding sites on serum albumin, thus increasing the plasma concentration of free warfarin. Since only the free drug is available for pharmacologic activity and metabolic degradation, the acute result is potentiation of anticoagulant activity as well as accelerated disappearance of the drug. In the steady state, decreased protein binding of warfarin continues but is balanced by enhanced metabolism, giving a zero net effect on the daily warfarin dose necessary to maintain anticoagulant control.<sup>5</sup> Chloral hydrate has a relatively low abuse potential and is therefore classified as a Schedule IV controlled substance. Schedule IV prescriptions can be written or telephoned and may not be refilled more than five times nor after a maximum period of six months.

# MARGIN OF SAFETY

Flurazepam (Dalmane®) has a wide margin of safety and has been claimed to be "ineffective as

a suicidal agent and probably does not interact with the coumarin anticoagulants."21 In wellcontrolled studies, involving chronic insomniacs, 30 mg of flurazepam was more efficacious than either 1 gm of chloral hydrate or 500 mg of glutethimide in inducing and maintaining sleep. In these and previously mentioned studies,14,15 flurazepam had little effect on REM sleep. The safety of flurazepam in women who are or who may become pregnant has not been established; reproduction studies in rats have not shown abnormalities.<sup>22</sup> Flurazepam is thought to be less likely to cause hangover than other hypnotics.<sup>23</sup> Due to its low potential for abuse, flurazepam is not subject to any of the controlled substance restrictions.

#### CONCLUSION

Methaqualone appears to be an effective sedative-hypnotic but has not demonstrated any advantage over other sedative-hypnotics.<sup>21</sup> It is being widely abused, possesses a narrow therapeutic range and may produce serious toxic reactions, has a potential for both physical and psychological dependence, and therefore cannot be considered a drug desirable to medical practice.

#### REFERENCES

The references noted in this article are available on request from either the author or the Journal of the Iowa medical society.

# Morbidity Report, June 1974

Disease	June 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties	Disease	June 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties
Amebiasis	6	14	12	Boone, Pottawattamie	Influenza,				
Brucellosis	- 1	8	3	Dubuque	lab confirmed	1	117		Polk
Chickenpox	453	6113	10726	Dubuque, Pottawattamie,	Meningitis, type				
_				Winnebago	unspecified	2	17	12	Keokuk, Muscatine
Conjunctivitis	49	518	798	Black Hawk,	Meningitis, asep		7		Polk
				Pottawattamie, Scott	Mumps	49	1606	2973	Scattered
Cytomegalovirus					Pediculosis	17	245	96	Dubuque, Floyd, Jasper
infection	3	28	3	Johnson, Story					Muscatine
Encephalitis, type					Pinworms	ı	30		Polk
unspecified	. !	13		Jefferson	Pneumonia	53	556	664	Scattered
Encephalitis, vira		- 11		Linn	Rabies in animal	s 16	72	135	Scattered
Enteropathogenic					Ringworm, body	2	97	68	Black Hawk, Buchanan
E. Coli	3	8	4	Dubuque, Jackson	Rocky Mountain				
Erythema					Spotted Fever	1	1	4	Clinton
infectiosum	55	511	1337	Jasper	Rubeola	75	103	273	Benton, Clayton,
Gastrointestinal									Dubuque, Scott
viral inf.	141	5485	5236	Floyd, Ida, Johnson	Roseola	2	9		Dubuque, Johnson
Giardiasis	9	23	7	Boone, Hardin, Johnson,	Salmonellosis	24	83	264	Scattered
				Polk	Scabies	7	52	8	Johnson, Marion,
Hepatitis,									Marshall, Muscatine
infectious	24	176	132	Linn, Polk, Scott,	Shigellosis	33	97	75	Scattered
				Woodbury	Streptococcal				
Hepatitis, serum	11	53	22	Johnson, Muscatine, Scott	infections	570	6647	4350	Jackson, Johnson, Polk,
Hepatitis, type	,	••		I. D.H. C			0017	.500	Pottawattamie
unspecified	6	20		Linn, Polk, Scott	Toxoplasmosis	2	4		Buchanan, Emmet
Herpes simplex	15	54	36	Johnson	Tuberculosis,	-	•		buchanan, Emmer
Histoplasmosis	!	8	3	Johnson	active	10	56	65	Scattered
Impetigo	6	194	203	Cass, Scott, Warren,	Tuberculosis.	10	50	03	Scallered
Infectious				Wright	inactive	- 1	8	13	Linn
		=00	4==	1.1 5.11	Venereal Diseases		8	13	Linn
Mononucleosis	62	589	453	Johnson, Polk		•	2007	2022	nl 111 1 11 2 2 2
Influenza-like	140	00222	112/0	0 ( ) ! !	Gonorrhea	430	2987	2932	Black Hawk, Linn, Polk,
illness	140	89333	11368	Crawford, Linn,	c 1.11				Scott
				Muscatine, Warren	Syphilis	34	213	198	Scattered

# Some Opportunities and Issues in Medicine

ROBERT Q. MARSTON, M.D. Charlottesville, Virginia

Constructive and meaningful discussion of moral and ethical issues is essential today. Included in this, says the author, are such topics as manpower, financing, the science base, and research.

The opportunities in medicine, in the absolute sense, are as they have been throughout history. Unusual opportunities of service to one's fellow man, assurance of a useful life, an intellectually-stimulating profession, and a certain degree of relief from some of the pressures that may plague others, such as personal income, or respect in the hierarchy of the community. Sir William Osler commented on the polar aspects of medicine, "There are individuals, doctors and nurses, for example (he said at Johns Hopkins in 1891), whose very existence is a constant reminder of our frailties; and considering the notoriously irritating character of such people, I often wonder that the world deals so gently with them."

But in that same address, that great and wise physician also stated: "In the gradual division of labour, by which civilization has emerged from barbarism, the doctor and nurse have been evolved, as useful accessories in the incessant warfare in which man is engaged."

# TODAY'S APPEAL

While in an absolute sense little has changed, in a relative sense, three factors make the profession more appealing than ever before: 1) Today the biomedical sciences constitute the most

dynamic area of intellectual activity in the whole universe of man's knowledge, 2) The shift from a world focused on the production of goods to one which emphasizes post-industrial service has given medicine primary status in this service sector, and 3) Finally, the implication of a zero growth society, with all of its dislocations and foreclosures of opportunity in many areas, instills medicine as an island of relative security when compared with other career opportunities. Thus, perhaps, it is not surprising to see large proportions of incoming classes in universities declaring an interest in the profession of medicine. The appeal of medicine to the brightest and most fit of our youth speaks eloquently to the opportunities. The fact that this is occurring in countries where the economic rewards are not as high as in this country suggests this appeal cannot be explained by high income potential.

Five issues are particularly worthy of comment. The first is physician manpower. My comments pertain to physician manpower rather than health manpower generally. On the one hand, the President and the Assistant Secretary for Health have suggested the possibility of an oversupply of physicians. On the other, 47% of physicians licensed in the U.S. last year were graduates of foreign medical schools. Then, too, there is no evidence that increasing the number of physicians will in fact improve medical care. Therefore, there is increasing emphasis on ways to improve uneven geographic and specialty distribution. There is discussion of voluntary or compulsory national health service in understaffed areas. Increasingly, one hears at state and national levels the goal is to have 50% of the medical graduates become primary care physicians. Some are seeking to monitor the mix of specialty training opportunities to achieve improved distribution by specialty. Then, there is discussion of task analysis of various activities carried on today by the physician with the idea that some portion of this workload might more appropriately be carried out by other members of the health team.

Although many things can be said, at length,

This keynote address for the 1974 Scientific Session of the Iowa Medical Society was presented on April 18 in Iowa City. Dr. Marston is Scholar in Residence, University of Virginia; Distinguished Fellow, Institute of Medicine, National Academy of Sciences, and President-elect, University of Florida, Gainesville, Florida.

about the manpower problems, I offer two cautions. First, one cannot resolve this problem through the educational process, either by increasing the numbers of physicians produced or by changing the curriculum to, say, produce more primary care physicians. Unless one has a clear idea of the system in which the manpower will work, the other factors are at best, "shots in the dark." The second caution involves the increasing problem of foreign medical graduates. This situation is dramatically displayed in the three tables. They demonstrate a national disgrace from three standpoints: 1) quality dilution, 2) brain drain, and 3) foreclosing career opportunities for U. S. citizens.

#### PAYMENT MECHANISMS

The second issue concerns the mechanisms for payment of health services, especially for physician services. The stage seems set for national health insurance, in one form or another, in the next few years. But completely unresolved are the conditions under which national health insurance will be implemented. For example, debates continue about PSRO, HMO's and prepayment versus professional fees. The conditions under which health services are purchased will influence directly the substance of the practice of medicine. Not entirely facetiously, I suggested a few months ago that one interested in health policy might well spend time more productively in the Social Security Administration than in the "Health" part of the Department of Health, Education and Welfare.

The third issue is the difficult one of need for medical services versus demand for medical services. As the health of a nation improves, usually through a combination of factors of which health care is only one, the achievement of additional improvement, particularly in such indices as mortality or morbidity, may be difficult or may occur only at great costs. We do know a few things about need versus demand. First, among the disadvantaged of this country today or, say during a depression, medical services are not the first priority. In our ghettos, health ranks about sixth, behind such things as food, housing, jobs. However, under more affluent conditions, it seems the consumption of medical services has no upper limit. There are areas in this country and the world with good physician-population ratios where complaints of an overall deficiency of services continue to be heard. In the U.S.S.R., there has been a deliberate attempt on the basis of communist doctrine to sell vigorously the con-

TABLE I
PHYSICIANS IN U.S.

	1964	1972
U. S. Graduates	245,550	288,525
FMGs	30,925	68,009
Total	276,475	356,534

sumption of health services. Indeed, the deputy minister of health told me he felt they had gone as far as they could go in terms of encouraging the use of medical resources by the population. But, now, as they move into improving the quality of such services through specialization and through the provision of more sophisticated procedures, he has no idea where the stopping point will be.

TABLE II

LICENSED TO PRACTICE

	1964	1968	1972
U. S. Graduates	6,605	7,581	7,815
FMGs	1,306	2,185	6,661
Total	7,911	9,766	14,476

As if this were not enough of a problem in and of itself, we really have great difficulties within the medical profession in defining need. In his book entitled, *Efficiency and Effectiveness*, Cochran concludes that although the British Health System has achieved the original goals of making health services available to the entire population at a cost which can be afforded, the output in terms of improved health has not matched the increased input of resources into the health system. He asserts a serious need to conduct far more "randomized clinical trials" to determine, in fact, which procedures are useful and which ones are useless.

#### SCIENCE BASE

The fourth issue is the question of the science base for medicine. Medical sciences constitute the most dynamic area of man's knowledge today, and yet, major issues have arisen not only in this country, but elsewhere, concerning the management of scientific research—a debate which rather curiously has placed those with scientific expertise on one side of the argument, and many of those whose expertise is in the area of societal expectations on the other. My own biases, perhaps predictably, can be summarized from a de-

TABLE III

COUNTRY OR REGION OF EMIGRATION OF FMGS FOR 1963 AND 1972

	Europe		Canada		Latin America		Asia		Other		Total
Year	No.	%	No.	%	No.	%	No.	%	No.	%	No.
1963	575	27.5	467	22.3	580	27.7	260	12.4	211	10.1	2,093
1972	911	12.7	439	6.4	372	5.1	4,996	69.9	425	5.9	7,143

bate I engaged in last fall at the Institute of Medicine of the National Academy of Sciences. The debate was on the Resolution: "That defining priorities for biomedical research is primarily the responsibility of the society as a whole rather than the scientific community." My thoughts as expressed in this debate follow.

I know the question of credibility is a critical point in this debate. Can scientists be expected to speak candidly in the nation's interest rather than in a self-serving fashion solely for their own, or their discipline's benefit? On the other hand, can the elected representative of society resist the temptation to bend science to support short-term political advantage?

Before entering into the negative side of this debate, I would like to make some general statements about biomedical research. The National Institutes of Health is a mission oriented agency, its particular responsibility is for the health implications of the research that it supports. However, it is useful to consider two other aspects of biomedical research: First, as a part of science generally. Secondly, there is the relationship of biomedical research to the university. This was expressed best of all in recent years by Clark Kerr, in his 1972 address to the Association of American Medical Colleges. He characterized biomedical science as the dominant intellectual drive in the university as a whole. In his words, "the health sciences are now the most important single part of all of higher education in the United States." Thus, I see biomedical research as very important to this nation and to the world, not only from the pragmatic standpoint of its contributions to health, but also as a "civilizing endeavor."

Specifically, it is a humanizing activity—although I suppose we have our share, but no more than our share, of the "arrogance of science." Frederick T. Gates, in talking about the Rockefeller Foundation in 1952, said: . . . "as medical research goes on, it will find out and promulgate, as an unforeseen by-product of its work, new moral laws and new social laws, new definitions of what is right and wrong in our relations with

each other. Medical research will educate the human conscience in new directions and point out new duties."

Furthermore, although I have spoken forcefully in support of the needs of biomedical research, I have emphasized the difficulty in assessing the particular level of resources which should be allocated to these needs in competition with the needs of other research and, indeed, of other social problems. A respected scientist made the decision a few years ago that energy was more important than cancer. I, personally, would make the decision that advances in the neurosciences broadly defined, may well be more important than cancer research narrowly defined, and indeed, that is a reason my last post at the National Institutes of Health was in the Neurology Institute. Perhaps the most important point of all is that the nature of progress in biomedical science will turn on the substance of that research, not on the labels or the loud assertions or the particular management tools employed. Thus, my plea will be that the decision-making process focus again and again and again on the substantive issues.

#### RESPONSIBILITY

Now, to the debate itself. I agree completely that, for that segment of research support that comes from the public treasury, the ultimate decision on biomedical research priorities is "primarily the responsibility of society." Having said this, I have to add that the notion of "society as a whole" is an amorphous concept, which obviously includes the scientific community as well as other components. Determining what society's priorities are is by no means a simple and straightforward task. The problem translates into: "Who speaks for society?" and "What are the processes by which 'society' makes its decision?" The voices claiming to speak for "society" are many and discordant—the Executive Branch, the Congress, the press, both lay and professionals, major study groups such as the Woolridge Committee, the Fountain Committee, the AMA Committee on Research, the Yarborough Committee, the Millis Committee.

All of these groups have their say and, eventually, a decision results which we conveniently refer to as, a "decision of society." My point, emphatically, is that society does not, as some suggest, express its priorities in science only through the process of electing a President!

The critical question is, how does society get the expert advice it needs? Whatever societal desires may be postulated, an indispensable datum for decision on priorities is the best possible scientific and technical estimate of what the possibilities and the probabilities of success are. Thus, in the planning stages, responsible public administration requires a careful weighing of expert scientific advice. In the execution phase, that is, after society has delivered its mandate and specified the level of intensity at which the mandate is to be pursued, those charged with carrying it out must be allowed to use their best scientific and technical judgment, bolstered of course, by sophisticated advice, to insure an optimal return on investments.

#### RESEARCH PRIORITIES

The basic question is how best to arrive at sound decisions on priorities for biomedical research which will take cognizance, both of the wishes of society and of the realities of science. Since I am a Scholar in Residence at the University of Virginia, it would be inappropriate to conclude without a quotation from Thomas Jefferson: "For here we are not afraid to follow the truth wherever it may lead, nor to tolerate any error so long as reason is left free to combat it." In Mr. Jefferson's terms—in order to utilize the strengths of science, it is essential to find some mechanism that makes it possible for those in and outside of the Federal Government to voice their best judgments and to speak candidly about scientific opportunities and the "state of the art."

Many feel the trend in recent times has been to depend too little on scientific advice in establishing priorities and to blunt the candor with which scientific advice is given.

Aside from the issue of how one allocates resources for biomedical research and determines the conditions under which the research is done, there is another emerging result of the growth of knowledge in medicine that has to do with the implications of the very fact that we have such knowledge. We are familiar with the more dramatic events such as end-stage kidney disease or sophisticated cardiovascular surgery or various

forms of cancer where heroic and expensive treatment sometimes results in rather dramatic results. What do we do in the medical profession with the knowledge that the incidence of myocardial infarction is eight times higher in individuals with a combination of hypertension, smoking, and high blood lipids, each of which are today at least a potentially reversible condition. I will touch on some other examples under the section on moral and ethical aspects of medicine, but here be mindful that social and individual choice, not deficient knowledge, may frustrate health improvements. Diet, smoking, alcohol, and drugs are obvious examples.

In Bangladesh I once sat in on a conversation that ran like this: A western friend asked his Bangladesh colleague how the nation could face the high annual death rate from cholera when it is now possible to cure the disease completely by fluid and electrolyte replacement. The answer was, how can the United States face the annual death rate from automobile accidents when that too is 100% preventable.

The final issue I would touch on is the question of social and ethical issues in medicine. Here the question of application of knowledge encounters a new constraint. Psychosurgery, mood-changing drugs, legal implications of increasing medical knowledge in mental illness, the rights of individuals to death with dignity versus the ability to preserve vital functions, the social ethics between the allocation of scarce resources for the benefit of a few by costly and manpower-consuming procedures versus the use of those resources for the benefit of larger numbers, to name only a few.

# PHYSICIAN JUDGMENT

While much of the focus has been on conditions under which experiments involving humans can be conducted, in good faith, I think we can expect increasing questions of the same type to be asked about the practice of medicine. About a year ago, I chaired a meeting of representatives of the western Europe Medical Research Councils. These questions have not yet been raised with the force in their countries as they have in this country, even in the research area. They shared my concern about the lack of good mechanisms for handling these problems once one moves away from a basic reliance on the good judgment of the individual physician. Morality by legislation has always been a frightening con-

cept, yet special protection is needed for experiments involving individuals with limited civil liberties, such as children, prisoners, or the mentally retarded. In other areas, at the very least, we should not only continue our present safeguards but welcome opportunities for open discussions of these matters.

Thus, I applaud the effort that Dr. Thomas Hunter is carrying out at the University of Virginia in his Medicine and Society Seminars. "The purpose of the program is to catalyse research and teaching across the boundaries of biomedical science and other disciplines in the University as they relate to complex problems of modern society. Virtually all of the latter have roots in value judgments and priorities. For this reason, the first focus had been on ethical problems which have come into prominence as a result of the advances in understanding of biological processes. Technological advances in biomedical sciences have opened up new possibilities which require a searching re-examination of the whole direction of human efforts towards the betterment of the future and of the quality of life."

Similarly, I have served during the last year on the Board of the Institute of Society, Ethics and Life Sciences. Although the issues raised in the sessions at the University of Virginia and at Hastings-on-the-Hudson have been difficult ones, they have convinced me, even more strongly, of the critical need to encourage constructive and meaningful discussions of the moral and ethical issues as they arise.

Let me turn back to the opening Osler quotation . . . "I often wonder that the world deals so gently with them" (doctors and nurses). This is a time when, justifiably or not, there is much discussion of the bad image of medicine generally, of its high cost, inefficiency, and of the high income of physicians. Coupled with this is our 100% failure rate in the sense that the "grim reaper" always wins in the end. In striking contrast to the possibility that these facts might lead one to expect the physician to be held in poor repute, we all know that the practice of medicine still heads the list as the most admired and respected profession. Individual physicians, at least, are looked on as being kind, wise and competent, and this is the type of perception one can't fake, thus the greatest issue of all may be that we maintain this humaneness of medicine as our capability for service increases.



# Pulmonary Endometriosis: Report of a Case

PAUL FROM, M.D., HARRISON W. PRATT, II, D.O., and JOSEPH TORRUELLA, M.D.

Des Moines

Histologically documented pulmonary endometriosis is a rare clinical entity characterized by recurrent or chronic pulmonary symptoms ranging from pain, hemoptysis, and pneumonia to recurrent pneumothorax. An eighth case of this clinical curiosity, occurring in a 29-year-old female, is presented, and the pathologic and clinical features are discussed.

For the vast majority of women, menstruation is a cyclic event of mild-to-moderate inconvenience. A small percentage, however, may suffer severe discomfort and occasionally mimic an acute abdominal emergency. Endometriosis tends to occur with decreasing frequency as the distance from the uterine cavity increases, with adenomyosis being more frequent than adnexal endometriosis, and the latter being much more frequent than intestinal involvement. Cyclic pulmonary symptoms, frequently catamenial pneumothorax, are uncommon, but in only a few cases is unequivocal endometrial tissue demonstrated histologically in lung tissue. This report documents an eighth case of pulmonary endometriosis.

#### PRESENTATION OF CASE

H. M., a 29-year-old gravida 2, para 2, white female, was seen in an out-patient clinic with sudden onset of dyspnea with central chest pain. The pain had been present for approximately two weeks, accompanied by fatigue, but no dyspnea

The authors are associated with the Departments of Internal Medicine, Pathology, and Surgery at Mercy Hospital in Des Moines, Iowa. Since the paper has been prepared, Dr. Pratt has relocated to the University of Wisconsin, Madison, where he is a resident in clinical pathology.

was experienced. Chest X-ray revealed 50% left pneumothorax, and she was referred to this hospital for treatment.

The patient gave a history of pneumonia 14 months prior to this event. She reported an admission to another hospital six months previously for emphysema, for which she had been receiving intermittent positive pressure breathing therapy. She also indicated having had pleurisy twice seven years before and once three years before.

Menarche was at 13 years. Prior to initiation of oral contraception, 10 years prior to this admission, her menstrual cycle was unremarkable. Six years after starting oral contraception, she stopped to become pregnant, then resumed oral contraception three years prior to this admission. One month before the development of pneumothorax, she had again discontinued oral contraception. Aside from some break-through spotting, no adverse symptoms referrable to the contraceptive were noted by the patient. There was no apparent relationship between her menstruations and pulmonary symptoms. She denied dysmenorrhea, menorrhagia, and prior uterine surgery, including dilatation and curettage.

Initial conservative management of the pneumothorax was undertaken using a chest tube, resulting in prompt reinflation of the lung. However, recurrence of the pneumothorax following removal of the chest tube necessitated surgical intervention. At thoracotomy, extensive blebs were found in the upper left pulmonary lobe, only the largest of which was resected in an attempt to preserve a maximum amount of pulmonary tissue. In addition, decortication, partial pleurectomy, and pleural abrasion were performed to prevent recurrence of the pneumothorax.

The postoperative course was uneventful. Pulmonary function tests revealed decreased total vital capacity (38% of predicted normal), consistent with the patient's bleb disease, but no significant alteration in other pulmonary function parameters. The patient was discharged on the

sixth postoperative day and placed on Enovid, 10 mg daily, with the plan to prevent menstruation for six months.

#### HISTOLOGIC FINDINGS

The specimen received consisted of two markedly congested fragments of thickened, hyalinized pleura, and subjacent emphysematous pulmonary tissue. Histologic examination of the lung tissue revealed multiple distended cystic structures, showing many giant cells and mesenchymal cells. A large fibrocystic structure resembled an emphysematous bleb. The alveolar epithelium was moderately metaplastic. Atelectasis, intra-alveolar hemorrhage, and a focal area of endometriosis were seen (Figures 1 & 2). The endometrial tissue consisted of six endometrial glands supported by an active stroma. The endometrial tissue was in intimate relationship with the pleura and fibrotic pulmonary parenchyma. There was no evidence of malignancy.

#### DISCUSSION

Symptomatic pulmonary endometriosis is a rare condition, first described in 1939 by Bungeler and Fleury-Silveria.1 This report documents an eighth case of this clinical curiosity. The bulk of the reported cases give a history of chronic or recurrent chest pain, hemoptysis, or pneumonia.2-5 With the exception of the case reported by Rodman and Jones,4 in which a nodule of endometrium was found in the bronchial wall, all the endometrial deposits have been confined to the pleura or the immediate subpleural areas. The pathogenesis of this condition has been theorized as being either metaplasia of lining coelomic mesothelium or vascular metastasis of endometrial fragments. Spencer<sup>6</sup> has stated that the relative rarity of pulmonary endometriosis with respect to other sites of endometriosis implies that metaplasia of lining cells is the more likely explanation. This view is countered by the finding of Simpson<sup>7</sup> in 1927 that endometrium was able to gain entry into the uterine blood vessels, a condition he termed "endometriosis vascularum," and by the successful transplantation of endometrial tissue to the lungs of experimental animals by Hobbs and Bortnick.8 A number of more recent studies in humans demonstrating embolized decidual tissue within the lungs of women tends to substantiate the theory of vascular embolization. 9-12 It is not unlikely, then, that showers of endometrial and decidual tissue

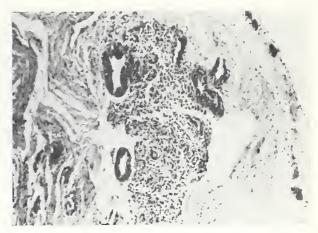


Figure 1. Focus of subpleural endometriosis embedded in wall of fibrocystic structure resembling an emphysematous bleb. Five glands and supporting stroma are seen. The pleural surface is to the right. (100×)

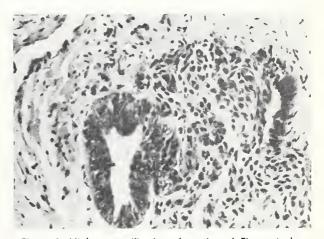


Figure 2. Higher magnification of portion of Figure I shows intimate relationship of endometrial glands and stroma to pulmonary tissue. (250 $\times$ )

periodically reach the lung with some regularity, probably in increased quantities, during and following labor or uterine surgery, although an explanation for the extreme rarity of survival of these emboli has yet to be documented.

Since the first reported case of pulmonary endometriosis, in 1939,¹ more clinical reports are entering the literature, and the phenomena of pulmonary endometriosis and catamenial pneumothorax are becoming accepted clinical entities. Crosby recently summarized the clinical features of pneumothorax associated with menses.³ Of 19 patients undergoing thoracotomy for catamenial pneumothorax, only eight had histologically demonstrable endometrial tissue in lung or pleura. Ten of 21 patients presented with symptomatic

(Please turn to page 363)



M. E. ALBERTS, M.D., Scientific Editor

# EAGER BEAVER TENDENCY

There is a tendency among some clinicians to "jump on the bandwagon" with each exciting new test or medication made available to the medical profession. Preliminary reports may prompt the inexperienced to accept the possibilities (not probabilities) too readily. This action may cost the patient added medical expense without valid return for his money. The latest indication of this eagerness seems to be with the sudden popularity of the nitroblue tetrazolium reduction test. In several years since the first report on this test by Park, et al, much has been written about its value in the diagnosis of bacterial infection. Now another report\* appears in the NEW ENGLAND JOURNAL OF MEDICINE to question the value of this test over conventional routine hematologic procedures.

Comparison was made of the NBT test with conventional hematology and the results indi-

\* Steigbigel, R. T., Johnson, P. K., and Remington, J. S.:

# T. L. C.?

Inflation is with us. Blame is directed at various segments of our society. It has been stated the farmers never had it so good. The labor unions have been accused of demanding too much, forcing consumer prices to rise. Now, the federal bureaucrats seem to imply the medical profession is entirely to blame. Our "price controls" were among the last to be lifted. We are now admonished to "hold the line," maintain the cate the routine white blood cell count and differential were more accurate in the diagnosis of bacterial infection. Bacterial infection was suggested by the presence of two or more hematologic abnormalities in 79% of the patients with bacteremia, while the NBT test done simultaneously was positive in only 50%. The authors concluded that this additional test over the routine "wbc and diff" and examination of the peripheral blood smear did not provide sufficient additional benefit to justify its routine use.

A lesson is to be learned here. When new "advances" are promulgated there is no valid reason in most cases to accept them immediately as the ultimate answer to whatever result is desired. Criticism is sometimes leveled at the unavailability of drugs which are available in other countries, for use in the United States. The tragedy of drugs causing teratogenic aberrations is well-known. For the most part we have very adequate diagnostic tools and therapeutic agents for our patients. We must be patient with new discoveries and not over utilize them over our own common sense and the expense of the patient.—M.E.A.

present fees, and become more productive if we need more dollars to meet our obligations in the inflationary economy.

What does increased productivity entail? Are we to see more patients per day and spend less time with each? Are we to delegate our responsibilities to ancillary personnel, thereby possibly providing a less satisfactory service? Are we expected to do less for our patients in order to see more—to be less sympathetic to their need to be heard? One of the greatest complaints about med-

Nitroblue tetrazolium reduction test versus conventional hema-tology in diagnosis of bacterial infection. N. Engl. J. Med., 290:235-238, Jan. 31, 1974.

ical service is the lack of communication; not enough listening and not enough explaining. An office operated like an assembly line is certainly to be criticized.

There are no easy answers to the problem. Certainly physicians cannot solve the problem of inflation for the entire social world merely by limiting the cost of medical care. Medicine is not the entire core of our socio-economic structure. Good health maintenance and good medical care for the ill and injured are necessary. There is the need also for food, shelter, plumbing, transportation, repairs of appliances, upkeep of the home, and, yes, even government. Everyone is responsible for the ultimate destiny of all. It is necessary for each segment of our society to look at itself in this regard, rather than taking "cheap shots" with unrealistic attitudes and unclear knowledge of all the facts at some other segment. Governmental bodies, especially individual vociferous politicians, must consider the whole, rather than criticize one individual or group. The vast majority of the American public is wise to the ways of governmental bodies that trade support for favored appropriations thereby increasing budget requirements, while at the same time strongly denouncing the gross national debt. This is a national disease, an epidemic involving all, and for one small group to be made the culprit does not protect everyone. Perhaps there is one ingredient that has been lost in the thought process of the policy makers—common sense, spiced a bit with basic intelligence.

Politics, to some, is characterized often by artful and often dishonest practices. Webster's New Collegiate Dictionary provides several definitions for "politician"—(1) one versed in the art or science of government, especially one actively engaged in conducting the business of a government, or (2) one primarily interested in political offices from a selfish or other narrow, usually short-run interest. Let us hope that our lawmakers and policy-makers are not of the latter type. Our country has been beset the past few years with enough dubious political activities. This is an illness that can be cured, but the treatment is not soft soap, hot oil, or some other form of irritant. Maybe the public would thrive on some T. L. C. (tender loving care) for a change.— M.E.A.

# PULMONARY ENDOMETRIOSIS

(Continued from page 361)

pelvic endometriosis, which was confirmed by surgery in six. One of three women undergoing surgery for other reasons was found to have ovarian endometriosis. These features suggest a strong correlation with pelvic endometriosis, but do not exclude either the metaplasia or embolization theory.

These reports should serve to alert clinicians to the possibility of pulmonary endometriosis or catamenial pneumothorax in the young female in the child-bearing years with recurrent pulmonary symptomatology. A careful gnyecologic history should be elicited with particular attempt to correlate the menstrual cycle and pulmonary symptomatology. Suppression of ovulation may produce relief of symptoms and obviate the need for thoractomy in selected patients, although if thoracotomy is performed, the pleural space should be obliterated to prevent recurrence.<sup>3, 5</sup>

# REFERENCES

The references noted in this article are available on request from either the authors or the journal of the iowa medical society.

# PAGE COUNTY MEETING

The Page County Medical Society, in cooperation with The University of Iowa College of Medicine, will present its 1974 Fall Scientific Program at the Country Club in Clarinda on September 11. Five hours of Category I credit are available toward the AMA Recognition Award and also in the American Academy of Family Practice program. The discussion will cover rheumatology, cardiology, pediatrics and immunology. For additional information, contact Kenneth V. Jensen, M.D., Secretary, Page County Medical Society, Clarinda, Iowa 51632.

# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

# SMALL VICTORIES

Today while walking a path in a nature preserve, and just before my foot came down upon them, I saw a flurry of scurrying ants. A closer look showed them to be two major opposite-moving currents across the path, forming a band about a foot wide. A few of them were carrying something, a fragment of twig, insect wing, green leaf. All those with burdens in their jaws were hastening to my left, sometimes laboring to wind their prize past obstructing thickets of grass, or sudden half-inch precipices of sand.

Many before me have been caused to ruminate on human affairs by watching insect behavior. For my part it made me remember something told me yesterday by a medical educator at another school. He had recently counselled a young physician who was considering the possibility of a career in continuing medical education. My friend told the young man it would be fine, as long as he was one who could be satisfied with small victories.

Yes, perhaps the victories are small ones . . . a word of sincere thanks . . . the telling about the lady saved from post-partum hysterectomy because her doctor had recently learned at a conference about ovarian vein thrombosis, how to recognize it and manage it with heparin therapy . . . the delight of the physician who identified the opening snap of mitral stenosis that he said he'd never have recognized except for the recent auscultation workshop he'd attended . . . the physician who grinned at me after a refresher course, "Well, I guess I'm not taking such bad care of my patients after all. . . ."

But the size of a victory and its significance depend so much on one's vantage point. That ant who finally dragged an empty pupa case up a sand hill neither knew nor cared that I watched his little triumph. He'd have done it anyway. And did it matter? I think so. For the world would be at its end if all of us stopped our efforts because they led only to small victories.

Dr. Caplan is Associate Dean, Continuing Medical Education at The U. of I. College of Medicine.

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# FOUNDATION FOR MEDICAL CARE HAS THIRD BIRTHDAY

This month the Iowa Foundation for Medical Care (IFMC) conducts its 1974 Annual Meeting. In doing so, the Foundation will observe its third anniversary.

Looking back to 1971, Iowa physicians created the IFMC in a further effort to demonstrate the profession's strong desire to assure good medical care for the residents of Iowa. Here's how the first of the Foundation's 11 stated objectives describes the total mission:

"To develop, promote and encourage the distribution of quality medical services to those served at an equitable cost and in appropriate quantity."

If these words are worthy of pursuit, and if they are now being achieved, it is the citizens of Iowa who are and will be the ultimate benefactors. It is the public that is served as the Foundation offers its professional review services to various third parties (insurance companies, Blue Shield, government, etc.). Day-to-day evaluation is now being made by Foundation physicians of all kinds of questions which concern the utilization (too much, too little) or cost of medical services.

This exercise—called peer review—is becoming better known to the public with each passing month and year. Peer review is that evaluation made by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians.

In 1973 nearly 900 such questions (or cases) were received and reviewed by the IFMC. In this first full year of operational peer review, the Foundation achieved notable success both qualitatively and quantitatively. Active and good participation by the Foundation's six district review committees is the major reason for this favorable record. The physicians who serve on these committees contributed an estimated 500 hours of professional time in 1973, either attending meetings or individually reviewing cases.

From these several summary figures, one can visualize the potential of the Foundation as a source of medical expertise.

Iowa physicians, by their creation of the Foundation in 1971, reaffirmed a commitment to providing high quality medical care in appropriate amount and at an equitable cost. In its early and formative months, the Foundation was confronted by a new development, i.e., the enactment of Public Law 92-603 with its PSRO provisions. This federal program is now moving from early to middle stage implementation. The medical profession in Iowa, as represented by the Iowa Medical Society, has determined it will act responsibly and professionally in instituting the PSRO law even though aspects of it are disconcerting.

The law indicates the Professional Standards Review Organization (PSRO) is to be organized, administered and controlled by the physicians within its specific jurisdiction. The PSRO must then operate a program which evaluates the necessity and quality of medical care delivered to individuals receiving governmentally-compensated medical care.

Until January 1, 1976, only a non-profit professional body representing most physicians in a given area can qualify as a PSRO. If such an organization fails to apply by 1976 and be properly designated, the Department of Health, Education and Welfare can pick any agency it thinks has the compentence to do the job.

The IFMC has applied for and received a PSRO planning designation. This means the Foundation will receive an allocation to support its planning activities pursuant to PSRO. Necessary corporate structuring to meet PSRO requirements is underway as is the refinement of plans to support the implementation of quality assurance programs in all Iowa hospitals. The next step will be that of seeking designation as a conditional PSRO.

Some public understanding of the Foundation program has been achieved. The PSRO program has also been discussed publicly. Efforts to educate the public and the total medical profession on these significant programs must be continued. They will be stepped-up whenever possible.

# IN THE PUBLIC INTEREST

# State Department of Health

# (Continued from page 349)

good lighting. However, when brushing for plaque control, a dentifrice should not be used since the foaming action tends to obscure visibility.

The patient should be encouraged to check the effectiveness of his cleaning at least once a week by using a disclosing wafer or liquid after cleaning. Repeated evidence of cleaning ineffectiveness should suggest a return to the dental office for evaluation of the technique and cleaning aids. A firmer brush, an electric brush, more frequent brushing, or additional cleaning aids may need to be recommended. Skill and effectiveness should not be considered adequate during the training program until the patient is able to clean all surfaces and remove all plaque without the use of a mirror. The routine use of floss as a habit can be more easily established if the patient is able to use the floss while doing other things such as reading or watching television.

# Selection of the Toothbrush

The brush should be designed and constructed to make accessible all areas of the mouth where debris and plaque may accumulate. The brush handle should be straight and the length approximately six to seven inches. The bristles should be of soft to medium texture and of nylon or similar material and a bristle diameter of .007 inch. The bristle tips should be polished and set in tufts no more than three rows wide. The brush head should be no more than one inch in length for adults and shorter for children. All bristles should be of the same length without a sawtoothed or convex brushing surface.<sup>7, 24, 28</sup>

When using the Charter's<sup>12</sup> technique, as in post-periodontal tissue management programs, a more firm brush may be recommended. The selection of the brush, as the selection of other aids for plaque control, will depend on the objectives, the oral conditions, and the limitations in the skill of the learner. If the patient is handicapped in dexterity, or if other limitations prevent the effective use of the hand brush, the electric brush may be helpful.<sup>20, 30, 34</sup> Care must be taken to select a soft bristle brush and one with the proper vibratory motion to assure sulcular cleaning.<sup>34</sup> When proper brushes and other aids are not easily available from local stores, the health practitioner is encouraged to contact local

suppliers and recommend stocking of the more desirable plaque control and oral health needs.

# Dental Floss as an Aid in Plaque Control

The floss should be of a small diameter and of sufficient strength to remain intact during passage through contacts and shearing the plaque colonies from the tooth surface.3, 7, 39, 43 Although the unwaxed floss is presumed to clean more thoroughly because of its small diameter and fibrous properties, there is no evidence, to date, that waxed floss cannot be just as effective. Where tight contacts cause frequent breakage, the stronger types of waxed floss may be preferred with little or no loss of effectiveness. Except in those rare instances of digital handicap, the floss aids or holders are of questionable value. The tautness of the floss in most holders prevents the wraparound procedure for effective surface cleaning.

# Perio-Aid as an Aid in Plaque Control

Many dentists are using the Perio-Aid or some similar instrument as an effective adjunct in plaque control.<sup>6, 43</sup> When special cleaning problems arise, this and other aids may augment the brush and floss. Such instruments should be recommended selectively since they may cause tissue damage if not used properly. It is suggested that careful instructions be given and the patient periodically evaluated for signs of inappropriate usage and tissue damage.

# Use of Dentifrice in a Program of Plaque Control

According to the Council on Dental Therapeutics of the American Dental Association, a dentifrice is a substance used with a toothbrush for the purpose of cleaning accessible areas of the teeth.

Agents may be added to the dentifrice in order to:

- 1. Lower the surface tension and thus serve as a spreader of dissolved material.
  - 2. Remove stain.
  - 3. Retard formation of calculus.
  - 4. Retard bacterial growth.
  - 5. Interfere with bacterial metabolisms.
  - 6. Buffer the bacterial byproducts.
- 7. Make tooth structure more resistant to caries activity.

However, until sufficient clinical research provides evidence of the therapeutic value of these agents in the control or prevention of dental caries or periodontal disease, their special contribution in a program of plaque control must be considered only tentative. To date, only fluorides have been shown to be effective as decay preventives in A.D.A. approved dentifrices. Undoubtedly, newer research will contribute additional evidence for better evaluation of the effectiveness of such materials. As stated previously, a dentifrice is generally not recommended when teaching the proper use of a brush or floss since the foaming properties prevent adequate visibility. To date, the use of a dentifrice has not been shown to aid in plague dispersion. However, for those children who may be benefited by the addition of fluorides to the dentifrice, any one of the A.D.A. approved dentifrices may be recommended.<sup>22, 24, 26, 40</sup>

The topical effect of fluorides is cumulative. Children should be encouraged to use a fluoride dentifrice even in optimum fluoride areas or where the children have had topical fluoride treatments.

# Use of Disclosing Materials in a Plaque Control Program

Most plaque disclosing materials are made with harmless food coloring and thus do not damage oral tissues, nor are they harmful if swallowed.4 There is some debate whether the actual staining observed is a true picture of the pathogenic microcosm since the constituents of the plaque's being stained are uncertain. However, the use of plaque disclosing wafers or liquid provide an ideal index of cleaning effectiveness and should be used routinely as a motivational device as well as a self-evaluation method. Each patient should be encouraged to check his own cleaning effectiveness at least weekly. Evidence of ineffectiveness in the cleaning routine should prompt an early return to the dental office for evaluation of the method and materials.

# Use of Fluorides in an Oral Health Maintenance Program

Fluorides, to date, have not been shown to be effective in the control of periodontal disease nor are they considered effective in the reduction or removal of the plaque microcosm. However, additional research may provide evidence that high concentrations of fluorides in an organic or other

matrix can reduce or attenuate the pathogenicity of plaque forming organisms.  $^{8,\ 23,\ 25,\ 26,\ 40}$ 

Topical fluoride applications and fluoride dentifrices are recommended as supplemental to water fluoridation as an effective and safe method to reduce the incidence of dental caries. Research has consistently shown that drinking water containing one part per million of fluoride can reduce the incidence of dental decay by as much as 60%. Topical fluorides, properly applied, may reduce caries incidence by as much as 40%, while the use of fluorides in a dentifrice may reduce caries incidence by as much as 20%. The use of fluorides in a program of oral health maintenance must be considered a necessary tool, along with effective diet control and plaque dispersion.

# Diet Evaluation and Its Use in an Oral Health Maintenance Program

Certain constituents of the normal human diet determine the rate of plaque growth as well as its pathogenicity. Sucrose is a fundamental constituent for rapid plague formation and for the subsequent high rate of caries incidence and tissue destruction. The restriction of sucrose from the diet may contribute significantly to caries reduction and periodontal disease for those patients in a program of oral health maintenance. While the amount of sucrose in the diet is important, the consistency of the sucrose containing food, when it is ingested, and the frequency of sucrose exposure are especially critical for dental disease control. An attempt should be made to determine the effect of the patient's diet on incidence of dental disease. When diet control measures are indicated, sucrose and other fermentable carbohydrates should be restricted to a single exposure per day An analysis of the food and liquid intake may suggest a prescription for disease control which may include substitute foods, altered pattern of food intake, or more frequent brushing and cleaning. Several excellent articles on the relationship between diet and dental disease have been included in the bibliography.9, 13, 21, 29

# Additional Aids in an Oral Health Maintenance Program

The use of forced water irrigation devices without the proper and effective use of other cleaning aids is of questionable value since they have not been shown to be effective in removing the well organized and mature plaque microcosm.<sup>5, 14, 24</sup> Currently, there is no evidence that commercial

mouthwashes have any preventive or controlling effect on either plaque or calculus formation. <sup>24, 26, 40</sup> However, carefully prepared fluoride-containing mouth rinses can be prescribed to enhance the protective properties provided by other fluoride applications and are particularly useful when there is evidence of rampant caries activity.

Evidence is only beginning to accumulate on the efficacy of using dextrinase and other enzyme inhibitors in the control of plaque formation.<sup>27, 31</sup> While early clinical trials look promising, the general use of such products in the control of dental disease must await additional clinical research.

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by TENORA MEYER, CMA

# PROSPECTS SOAR IN '74

September 22-29 has been proclaimed "Medical Assistants' Week" in Denver, Colorado. The AAMA national convention will be at the Denver Hilton from September 24-29.

There will be pre-convention tours and on Monday evening, September 23, everyone will gather for a "Rocky Round-Up" hosted by the Colorado Society of AAMA. Early events include a state presidents' conference and workshops on AAMA certification and curriculum review. The House of Delegates will convene Tuesday, September 24, at 8 p.m. Colorado dignitaries will include the Governor of Colorado, John D. Vanderhoff, William H. McNichols, Jr., Mayor of Denver, and Senator Peter H. Dominick.

Reference committee meetings will convene at 9 a.m. on Wednesday, September 25. That afternoon, local and state leaders may choose from several organizational workshops designed to strengthen AAMA as an association. Medical assisting educators will participate in a four-hour seminar on Wednesday.

Thursday, September 26, the House of Delegates will be in session with the CMA dinner scheduled to honor those who successfully passed the 1974 certification examination.

Friday and Saturday, September 27 and 28, will be devoted to educational sessions on the needs of medical assistants. Specialty programming will cover new developments and how they may affect the medical assistant. Medical fields to be featured tentatively include pediatrics, orthopedics, ophthalmology, surgery and family practice.

A new function this year will be the Presidents' dinner Friday, September 27. This event will recognize the leadership and contributions

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

of presidents at all three levels of AAMA. Entertainment will be provided by the famous Koshare Indian Dancers.

A Western evening, typifying Colorado's historical past, will be offered Wednesday, September 25. A Western beef barbeque at the Jefferson County Fair Grounds will include a horse pageant to be presented by the "Fort Westernaires."

Post-convention tours around Denver, Estes Park, Aspen, Durango, and Colorado Springs are available from September 29 to October 5.

This meeting is open to all Iowa medical assistants. Further information may be obtained by writing the American Association of Medical Assistants, Inc., One East Wacker Drive, Chicago, Illinois 60601, or you may address your inquiry to the Medical Assistant's page of this JOURNAL.

# LOOKING BACK ON SIOUX CITY

There were many favorable reports on the recent state convention in Sioux City. The Sioux City Medical Assistants are wonderful hostesses.

The CMA Mini-test was held. Pauline Tappan, state safety chairman, presented an interesting program on safety. Luella Mitchell, national trustee from Chicago, presented an instructive program on "Parliamentary Law." A panel on "Dual Review" was presented by Jeanne Green, Helen Sierk and Charlotte Lewis. This was of benefit to those preparing for the certification examination.

Officers for the coming year were installed by Jeanne Green at the Saturday night banquet. Joann James, Mason City, assumed the presidency of the State Association; Nancy Winter, Davenport, president-elect; Margaret Porter, Cedar Rapids, vice president; Leanna Rist, Des Moines, secretary; and Jean Gold, Davenport, treasurer.

# **About IOWA Physicians**

Dr. G. H. Utley, Clarence, has terminated his medical practice in Clarence to relocate in Cedar Rapids. Dr. Utley will join three family practitioners in a group practice. . . . Dr. William Stone, Waterloo, discussed "Emotional Problems in Childhood," at recent meeting of the community's Child Care Center. . . . Dr. Carl R. Aschoff has been named director of the Cedar Rapids Medical Education Program. Dr. Aschoff succeeds Dr. L. Robert Martin, who has been director since June, 1971. Dr. Martin moves to the University of California at Los Angeles, where he will be founding director and head of the division of Family Practice. Dr. Aschoff has been a family practitioner in Cedar Rapids for 20 years.

Dr. Harold Itskovitz, professor of medicine at Wisconsin College of Medicine in Milwaukee, was guest speaker at May meeting of Wright County Medical Society. Dr. Itskovitz heads the hypertensive section. . . . Dr. Manrice E. Kraushaar, Fort Dodge, has joined the Department of Family Practice at the Kersten Clinic. . . . Dr. John W. Eckstein, dean, U. of I. College of Medicine, has accepted a three-year term on advisory council of National Heart and Lung Institute. Dr. Eckstein will help evaluate NHLI research programs concerned with heart and blood vessel diseases. . . . Dr. James O. Stallings, Des Moines, was certified by American Board of Plastic Surgery in May.

Dr. Robert Boldus, Sioux City, is new president of Woodbury County Heart Association; Dr. William Jackson, Sioux City, is vice president.

. . Drs. Songyoth Sakdisri and Suthon Chatkupt, both of Thailand, recently joined Drs. Opas and Puangtong Jutabha, in medical practice in Sigourney. Dr. Chatkupt received the M.D. degree at Chiengmai University in Thai-

land. He served one-year internship in Thailand and one-year internship and four year residency at Kansas City General Hospital, Dr. Sakdisri received the M.D. degree at Mahidon University in Bangkok and served a one-year internship there. He served one-year residency at Women's Hospital in Bangkok and a three-year residency at Kansas City General Hospital, Kansas City, Missouri. . . . Dr. Rubin H. Flocks, professor and head, U. of I. Department of Urology, has received the Edward L. Keyes Medal, highest honor bestowed by American Association of Genito-Urinary Surgeons. Dr. Flocks, immediate IMS past president, has headed most of the top professional organizations in urology. . . . Dr. H. E. Rudersdorf, Sioux City, has been named to executive board of Iowa Heart Association.

Dr. Edward E. Mason, professor of surgery, U. of I. College of Medicine, is author of "Fluid, Electrolyte and Nutrient Therapy in Surgery," published by Lea and Febiger, Philadelphia. The book is for medical students, general surgeons and physicians and medical personnel who care for surgical patients. . . . Dr. L. A. Bascom, Nora Springs physician for 36 years, retired from medical practice July 1. Dr. and Mrs. Bascom will move to Texas where their two daughters reside. Dr. Bascom established the Nora Springs Care Center and Osage Nursing Home. . . . Dr. Walter Anneberg, Carroll physician for 50 years, was honored at a recent luncheon sponsored by the Carroll Chamber of Commerce. Dr. Anneberg is past recipient of the Chamber's Community Service Award and headed successful fund drive for new St. Anthony-Regional Hospital. . . . Dr. R. S. Domingo recently returned to Rohlf Memorial Clinic in Waverly after one year's absence. Dr. Domingo was with the Student Health Service at the University of Northern Iowa during this period.

Dr. Mazimo Napuli has joined the Keokuk Medical and Surgical Clinic. Dr. Napuli, a pediatrician, was born in the Philippines. He came to the United States in 1970 and completed a one-year rotating internship and a three-year pediatric residency. . . . Guest speakers at recent Organ Recovery Workshop in Sioux City were Dr. Robert Corry, Director, Organ Transplant Center, U. of I. College of Medicine, Dr. Richard Lawton, Director, Organ Recovery Program, U. of I. College of Medicine, Dr. George Spellman, Director, Dialysis Unit, St. Vincent Hospital, Sioux City, and Dr. Robert Boldus, member of Organ Recovery Team. The workshop was sponsored by U. of I. College of Medicine, Kidney Foundation of Iowa and Woodbury Medical Society. Forty northwest Iowa doctors, nurses and hospital administrators attended. . . . Dr. Stanley Greenwald, Iowa City obstetrician and gynecologist, was guest speaker at recent meeting of Iowa City, Cedar Rapids and Independence Area Ostomates. Dr. Greenwald's topic: "Sexuality and the Ostomate."

Dr. Barry E. Knapp, Sioux City pathologist, is new director of Externship Training Program at Community's St. Joseph Mercy Hospital. . . . Dr. A. C. Bergstrom, Missouri Valley, will retire this summer. A Harrison County physician for 43 years, Dr. Bergstrom received the M.D. degree at U. of I. College of Medicine and interned at Harper Hospital in Detroit, Michigan. The Community Memorial Hospital hosted a June banquet to honor Dr. Bergstrom. Dr. and Mrs. Bergstrom plan to live in Missouri Valley. . . . Dr. F. B. Leffert, Centerville, was recently honored by the Appanoose County Fair Association. Because of his long devotion to the youth of Appanoose County and his active interest in the business of agriculture, the 1974 County Fair was dedicated to Dr. Leffert. . . . Dr. J. W. Hughes, Marshalltown, spoke on "Care of the Orthopedic Patient," at recent continuing education program for licensed practical nurses in Fisher Community Center.

Former Iowa commissioner of public health, Dr. James F. Speers, has resigned as Omaha-Douglas County Health Director in Nebraska to accept a position with the Florida State Health Division. . . Dr. Sidney Sands, Des Moines, spoke at graduation exercises for final School of Nursing

class at Broadlawns Hospital. The school is being discontinued. Dr. Sands is director of medical education at the hospital. . . . Dr. Wallace Ash, DeWitt, was recently named "man of the year" by the DeWitt Central Teachers Association. Dr. Ash was cited for his work in youth athletic programs. A member of the DeWitt Recreation Commission, he has aided in securing a new Central High School track as well as lighting of high school tennis courts. . . . Dr. Henry J. Caes, Sioux City, is president of newly-organized Siouxland Health Education Program. The nine-county agency was initiated to structure innovative health educational projects and recently received additional funding from Iowa Regional Medical Program. . . . Dr. Rubin Flocks, head, Department of Urology, U. of I. College of Medicine, has received an honorary doctor of science degree from the Medical College of Ohio in Toledo.

Dr. Richard Miller, Waterloo, discussed fetal heart monitoring at recent meeting of American Association of Coronary Care Registered Nurses in Waterloo. Dr. Miller, diplomate of American Board of Obstetrics and Gynecology, and fellow of Colleges of Surgeons and Obstetrics and Gynecology, has been active in setting up the perinatal unit at Waterloo's St. Francis Hospital. Dr. Rose Marv Mason, and associate of Dr. H. K. Merselis in Audubon the past year, has opened a solo practice of medicine in that community.

### **DEATHS**

Dr. B. C. Luchrsmann, 68, Dyersville physician for 44 years, died June 16 at Mercy Medical Center in Dubuque of an apparent heart attack. Dr. Luchrsmann received the M.D. degree at Loyola University School of Medicine in Chicago and interned at Chicago's St. Anne Hospital. He was a member of the Iowa Medical Society and American Medical Association.

Dr. George S. Marquis, 82, of West Des Moines, died June 30 at Iowa Lutheran Hospital in Des Moines. A graduate of University of Kansas Medical School, Dr. Marquis, an eye, ear, nose and throat specialist, retired from active practice in 1972. He was a veteran of World Wars I and II and a life member of Iowa Medical Society and American Medical Association.

### LIST YOUR WANTS

No charge is made for the ads of members, wives of deceased members of the Iowa Medical Society or physicians seeking Iowa locations; for others the cost is \$1.00 per line, \$5.00 minimum per insertion. Copy for ad must be received by the seventh of the month for the following issue. Send to JOURNAL OF THE IOWA MEDICAL SOCIETY, 1001 Grand, West Des Moines 50265.

FOR SALE—Used Burdick EK-3 Electrocardiograph in very good condition with carrying case, spare stylus, and Burdick stand on wheels. \$325. Contact T. Dynes, M.D., Decorah, Iowa 52101. Phone 319/382-3616 days.

GENERAL PRACTITIONER NEEDED: Practice with complete freedom of action in a rural atmosphere? Office next to pharmacy, ready for occupancy, no unseen strings. Moville, Iowa, 15 miles east of Sioux City offers just such a chance. Contact Moville Community Development Association, Inc., Moville, Iowa.

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WANTED—FAMILY PRACTITIONER to associate with clinic group in northcentral Iowa. Community of 32,000. Excellent salary with planned time off. Replies confidential. Write No. 1497, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

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PHYSICIAN TO JOIN present staff of Board Certified Internists and Generalists as Ward Physician on active Medical Service of 200 beds in Dean's Committee hospital. Salary dependent on qualifications. Liberal fringe benefits, Non-discrimination in employment. Send inquiries and curriculum vitae to Chief, Medical Service, Veterans Administration Hospital, 30th and Euclid, Des Moines, Iowa 50310.

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PHYSICIANS—WORLDWIDE—Spain, Japan, Hawaii, Maine, Florida, California, other areas—General Practitioner or Specialist needed. Practice primary health care. No overhead. Continuing/graduate medical education. Research. Thirty days paid annual vacation. Comfortable salary. Contact: LCDR A.E. PIATT. MSC, USN, Medical Programs Officer, Navy Recruiting Area SIX, 6910 Pacific Street, Suite 100, Omaha, NE 68106 or Telephone: 800-841-8000 toll-free.

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FAMILY PHYSICIANS—unique practice opportunity in an incorporated 28-man group in east central Wisconsin. New clinic facility across the street from 450-bed hospital. Ideal cultural and recreational setting. Opportunity to develop special interests in acute and ongoing adult care and/or industrial medicine. Equal stockholder in one year. Excellent pre-tax fringes. Write or call Malcolm L. McCutcheon, M.D., Nicolet Clinic, S.C., 211 N. Commercial Street, Neenah, Wisconsin 54956. Telephone 414/725-7071.

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VACANCY—ADMITTING, PRIMARY CARE, PERSONNEL PHY-SICIAN. Desire physician interested in academic university affiliation, preferably board certified in family practice. Five day week, nights free. VA benefits and retirement. Salary \$26,000 to \$32,000 depending on qualifications. Nondiscrimination in employment. Inquire: Chief of Ambulatory Care, VA Hospital, Iowa City, Iowa 52240. Phone 319/338-0581.

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For further information on this subject, the following references are provided:

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2. Hollister LE, et al: Arch Gen Psychiatry 24:273-278, Mar 1971. 3. Claghorn J: Psychosomatics 11:438-441, Sept-Oct 1970.



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in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-pearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate ts action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

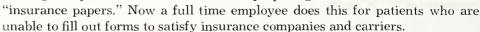


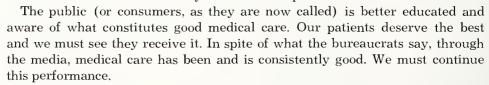
## President's Page

Some mail received at IMS headquarters from persons eligible for membership amazes me. It reminds me a little of the boy who wouldn't play the ball game unless he made all the rules. And if he owned the bat or ball, the game was in greater jeopardy. This kind of mail comes infrequently, but it does require attention.

Most physicians realize we cannot practice as we have in the past. In former years we had to convince patients hospital care was beneficial. Now we must often persuade them against unnecessary hospitalization, or urge them to leave the hospital and relinquish dependence on complete care.

When insurance and government became major sources of payment for medical care, I spent an evening every week or two at the office preparing





Now comes PSRO. It is the law. It will require adjustment, but certainly the review system is not new. My first recollection of peer review was by way of clinical pathological conferences, then utilization review, then the Medical Society medical review committee. Some elements of the law need revision but let's maintain our firm belief that the review system should be under the control of local physicians.

Further changes seem inevitable with national health insurance a near certainty. Even more intense scrutiny will be required by the profession.

Sincerely.

Ralph L. Wicks

Ralph L. Wicks, President



FOUNDATION ELECTS . . . Four Iowa physicians have been elected (or re-elected) to 3-year terms on the board of the Iowa Foundation for Medical Care. Announced at the August 4 annual meeting was the election of M. H. Dubansky, M.D., Des Moines, P. T. McGarvey, M.D., Waterloo, P. M. Seebohm, M.D., Iowa City and J. H. Sunderbruch, M.D., Davenport. The 1974-75 IFMC Executive Committee includes K. E. Lister, M.D., Ottumwa, president; R. J. Dawson, M.D., Estherville, 1st vice president; Dr. Sunderbruch, 2nd vice president; J. H. Brinkman, M.D., Mason City, secretary and Dr. Dubansky, treasurer.

BLUE SHIELD BOARD . . . Herman Smith, M.D., Des Moines, and John Anderson, M.D., Boone, are newly-elected BS board members. Dr. Smith assumes a 3-year at-large term and Dr. Anderson a 1-year IMS at-large slot. Re-elected were D. R. Rodawig, Jr., M.D., Spirit Lake, C. W. Seibert, M.D., Waterloo, J. R. Scheibe, M.D., Bloomfield, E. B. Mathiasen, M.D., Council Bluffs, J. J. Redmond, M.D., Cedar Rapids, W. M. Krigsten, M.D., Sioux City, A. H. Downing, M.D., Des Moines, L. Call Dickinson, Des Moines, and Harris Feldick, Storm Lake.

STUDY OBESITY... New IMS committee is being formed to re-study criteria for obesity surgery. This re-evaluation has been requested by the Society's Subcommittee on Medical Review.

1975 HOUSE SESSION . . . 1975 Annual Meeting of the IMS House of Delegates will be Saturday and Sunday, April 26 and 27, in Des Moines, at the new Hilton Inn on Fleur Drive.

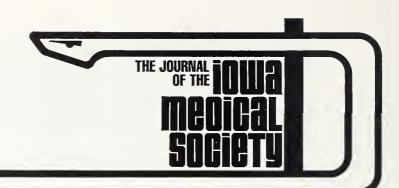
PA'S... Suggestion has been made to Board of Medical Examiners that it include in its rules and regulations a provision for the physician's assistant to prescribe drugs (other than Schedule II) following a protocol devised by the supervising physician and approved by the BME.

IMMUNIZATION ACTION MONTH... October is designated Immunization Action Month. IAM is a national cooperative effort to reverse the alarming trend of declining immunization levels among 1-4 year old children. Educational and motivational programs are being planned. A Governor's proclamation and news conference will launch the observance in Iowa. The IMS Committee on Maternal and Child Health and the Woman's Auxiliary to the IMS are represented on the Immunization Action Advisory Committee. County societies and individual physicians are urged to support the project at the local level.

HEALTH PLANNING . . . Statement drafted by Iowa Regional Medical Program and Office for Comprehensive Health Planning entitled "Proposal to Reorganize Health Planning and Health Resources Development in Iowa" was discussed at summer meeting of IMS Executive Council. Statement coincides with federal legislative proposals which call for merger of CHP, RMP and areawide health planning councils into a single non-profit agency outside state government. Legislative proposals have planning and development functions separate from state-assigned regulatory functions. IRMP and OCHP are planning 15 areawide conferences to gather opinions on the direction of health planning in Iowa.

CONTINUING EDUCATION... Testimony from various state professional and occupational licensing boards has prompted the Legislative Interim Study Committee on Professional and Occupational Licensing to request an Attorney General's opinion on establishment of continuing education requirements by regulation and not by statute.

**SERVES...** IMS Executive Vice President D. L. Taylor is serving on special AMA advisory committee to evaluate formation of a National Association of Professional Standards Review Organizations.



VOL. 64 No. 9 SEPTEMBER, 1974

TABLE OF CONTENTS		SPECIAL DEPARTMENTS			
		President's Page	380		
Office Detection of Cervical Neoplasia		lowa Medical Miscellany	381		
Herbert J. Buchsbaum, M.D., William A.		State Department of Health	383		
Davis, M.D., and James G. Blythe, M.D.	387	The Question Box	386		
Reflections on Colon Surgery James F. Bishop, M.D.		In the Public Interest	401		
	391	Educationally Speaking	405		
The Iowa 500: A Comprehensive Study of Mania, Depression and Schizophrenia John Clancy, M.D., Ming-Tso Tsuang, M.D., Barbara Norton, MSW, and George		Medical Assistants	407		
		About Iowa Physicians	408		
	224	Deaths	411		
Winokur, M.D.	394				
		MISCELLANEOUS			
EDITORIALS		Continuing Education Courses and Confer-			
Acupuncture—The Needle	300	ences	393		
Acupuncture—The Needle	333	Add 16,689 in 1973	398		
Good Medicine: Good Manners 3		A New Opportunity for Physician's Nurses .	406		

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### State Department of Health

### PUBLIC HEALTH IMPLICATIONS OF HEPATITIS B ANTIGEN IN HUMAN BLOOD

For many years viral hepatitis has been known to occur in two major forms: infectious hepatitis and serum hepatitis. They are clinically indistinguishable in individual cases, but may be differentiated on epidemiologic grounds. The "infectious" type has an incubation period which varies from two to six weeks in length. It is spread primarily by the fecal-oral route, and has relatively high secondary attack rates among family and other very close contacts. Serum hepatitis has been characterized by a six-week to six-month incubation period, is transmitted by other than the enteric tract, with secondary spread limited to persons receiving needle punctures or blood products contaminated by the index case. Routine pooled human immune serum globulin ("gamma globulin") is protective against secondary cases of infectious hepatitis among family and other close contacts of an index case but it has never been effective in protecting susceptible individuals against parenteral transmission of serum hepatitis.

The epidemiologic distinction between serum and enteric transmission has become somewhat clouded by observations that "infectious" hepatitis can be transmitted by blood transfusions and other parenteral exposures, while under certain circumstances "serum" hepatitis has been transmitted through the enteric tract. Perhaps partly because of this overlap in transmission routes, newer terminology using "viral hepatitis type A" and "viral hepatitis type B" instead of the traditional "infectious" and "serum" designations, respectively, has become widely used in recent

years. The Iowa State Department of Health prefers the use of the "A" and "B" terminology to the older "infectious" and "serum" categories, respectively.

A highly significant research development in recent years has provided a laboratory test capable of differentiating between these two forms of hepatitis in many cases. A substance found by chance in the blood of an Australian aborigine, therefore originally referred to as the "Australia antigen," has been defined as being closely associated with type B viral hepatitis. This antigen is now referred to as the hepatitis B antigen (or HB Ag). For all practical purposes, the detection of this antigen in the serum of a hepatitis patient either shortly before or during the first week after the appearance of clinical hepatitis can be considered diagnostic of hepatitis type B. Such a patient should be considered as likely to have acquired his infection and to be capable of transmitting it via the parenteral route rather than via the enteric tract, and at present, there is no indication for the use of immune serum globulin to protect family or other close contacts of such cases.

In its Morbidity & Mortality Weekly Report of April 6, 1974, the HEW Center for Disease Control has published an updated statement by the Committee on Viral Hepatitis of the National Academy of Sciences and the National Research Council concerning public health implications of the hepatitis B antigen. This statement supports the above approach to the etiologic diagnosis of hepatitis and the use of gamma globulin. It also offers information and recommendations pertaining to the screening of blood donors, routine screening of other population groups, management of chronically HB Ag positive persons, and the probable occurrence of congenital transmission of hepatitis B. The statement of the Committee appears on the following page.

### UPDATED STATEMENT ON VIRAL HEPATITIS

A clearer definition of the significance of viral hepatitis type B as a clinical and public health problem has arisen from the discovery, development, and widespread application of various serologic tests for the presence of an antigen—hepatitis B antigen—that is associated with the disease. The demonstration of the antigen in the blood of a patient or of an apparently healthy person raises questions not only of the presence of active liver disease, but also of the potential risk of transmission of the infection to others. It is now recognized that, in addition to the well-established parenteral mode of transmission, viral hepatitis type B can be transmitted by other means.

On the basis of information acquired from clinical and epidemiologic studies and from antigen testing programs, the Committee on Viral Hepatitis finds that:

- 1. A confirmed positive test for antigen is indicative of acute or chronic viral hepatitis type B or of an asymptomatic carrier state.
- 2. The presence of the antigen in the blood of a patient with acute viral hepatitis type B is usually transient. If it persists for more than 3 months after the onset of illness, the person is likely to become a chronic carrier of the antigen.
- 3. A chronic carrier of the antigen may or may not have demonstrable evidence of related liver disease.
- 4. The occurrence of acute hepatitis type B or an asymptomatic carrier state during pregnancy or even during the first 2 months post partum is frequently associated with later infection in the newborn infant.
- 5. There is clear evidence that carriers should be prohibited from donating blood for transfusion.
- 6. Although the infectiousness of patients with antigen-positive hepatitis apparently diminishes when the antigen is no longer demonstrable in the blood, they are currently not accepted as blood donors.
  - 7. There is insufficient knowledge of the extent

to which chronic carriers can transmit hepatitis type B by nonparenteral routes. However, close contacts of some categories of chronic carriers, such as renal dialysis patients, are at increased risk for hepatitis type B infection.

- 8. With respect to risk of transmission to others, there is no indication at this time that routine antigen testing of any specific professional or occupational group should be required.
- 9. Standard Human Immune Serum Globulin (ISG) is of no demonstrable value in the treatment of carriers.
- 10. There is insufficient evidence on which to recommend the use of standard ISG for prophylaxis among contacts of hepatitis B patients or carriers. Studies of the possible prophylactic effect of hepatitis B hyperimmune serum globulin are currently in progress.

The Committee recommends that:

- 1. Persons found to have a positive antigen test in the course of diagnostic studies, blood-donor testing, or testing after known exposure to infection with hepatitis type B be so informed and the test be repeated promptly; and persons with a confirmed positive test be evaluated for the presence of liver disease and followed to determine whether the antigen persists.
- 2. Persons with antigen-positive hepatitis be considered infectious and control measures be taken with respect to potentially infectious materials, such as blood and blood-contaminated secretions.
- 3. Women found to have hepatitis during pregnancy or during the first 2 months post partum be tested for hepatitis B antigen and their infants be tested for hepatitis B antigen at monthly intervals for at least 6 months.
- 4. Testing for hepatitis B antigen be required of all blood donors.
- 5. Until more complete knowledge of the significance of the antigen carrier state is acquired, particularly as to its relation to communicability, only routine precautions, such as those applying to percutaneous routes of potential transmission, be initiated.
- 6. The effort to obtain more accurate and complete reporting of hepatitis cases—on the basis of serologic test results as well as epidemiologic characteristics—be intensified to improve surveillance on a national basis.

This revised statement has been prepared by the Committee on Viral Hepatitis of the Division of Medical Sciences, National Academy of Sciences-National Research Council.

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### The Question Box

by C. H. DENSER, JR., M.D.

Dr. Denser is chairman of the Iowa Medical Society Medico-Legal Committee. He comments here on the Committee's number-one topic, professional liability insurance in Iowa.

### What is your assessment of professional liability coverage in Iowa?

The subject almost defies brief assessment. Our situation in Iowa appears to be better than in some parts of the country. The Insurance Commissioner has approved increased rate filings in recent months, but supposedly these are the first in close to two years. Coverage in Classes IV and V has become harder to locate. Several companies continue to be somewhat active in the Iowa market.

### Are individual coverage problems increasing or decreasing?

In recent weeks we've noticed a larger than usual number of questions and requests for help

### IOWA MEDICAL MISCELLANY

EYE TEST KIT... A new and free home Eye Test Kit is available on request from the Iowa Society for the Prevention of Blindness. The kit is for use by parents in checking the vision of the preschool-age child and is supplementary to the screening programs sponsored by the Iowa Society in more than 190 Iowa towns. Support for the test kit has been given by the American Academy of Pediatrics. The Society address is 1011 Locust, Des Moines 50309.

from Society members. We are pleased that in some instances we have been able to provide some aid. We are glad to try.

### What has been the recent activity of the Medico-Legal Committee?

We've just completed a survey of state medical societies to gain a first-hand impression of what's happening elsewhere. No thorough analysis has been made of these responses as yet. We've met recently with a representative of the Insurance Commissioner as well as with a home-office executive of the state's principal liability insuror.

### How does Iowa's professional liability picture compare with other of the states?

Several states have serious problems. New York and New Jersey are two examples. Aside from premium boosts, and these are bearable by comparison, the heartland states seem to be experiencing less difficulty.

BOOKS... A "Core List of Books and Journals for Health Science Libraries" has been devised by the Iowa State Advisory Committee on HSL's. The list is specifically designed for the small hospital. In addition, a library consulting service is available to health institutions from the Advisory Committee. More information is available from E. A. Holtum, Coordinator for Health Science Libraries in Iowa, Health Sciences Library, University of Iowa, Iowa City 52242.

HONOR KINGERY . . . Ed Kingery, retired executive secretary of Polk County Medical Society, received an Alumni Award in June from his alma mater, Grinnell College. Award recognizes Ed's long and able service to medical profession.



### Office Detection Of Cervical Neoplasia

HERBERT J. BUCHSBAUM, M.D., WILLIAM A. DAVIS, M.D., and JAMES G. BLYTHE, M.D.

Progress in detecting cervical carcinoma is acknowledged. Much has been learned about the histogenesis of cervical neoplasia. Procedures recommended in establishing its diagnosis are set forth.

Cervical carcinoma is the most common female genital malignancy with approximately 30,000 new cases diagnosed annually. It is estimated that 400 new cases are detected annually in this State and that 100 Iowans die of cervical carcinoma per year. The past 20 years has seen a significant decrease in deaths from this disease. While progress has been made in radical pelvic surgery and in radiation therapy, the most important factor in the decreasing number of deaths from cervical carcinoma has been earlier detection. The family physician, as primary care physician, plays a major role in combatting this disease.

In spite of the great strides made in early de-

tection, some confusion still exists regarding the steps in establishing the diagnosis of cervical neoplasia. It is the purpose of this paper to outline the procedure utilized in the Department of Obstetrics and Gynecology, University of Iowa Hospitals, so that it may serve as a guide to others.

### HISTOPATHOLOGY

The accessibility of the cervix to speculum examination and specialized studies have helped us to learn a lot about the histogenesis of cervical neoplasia. As a result of colposcopic, colpomicroscopic, cytologic and histologic examination, we know that cervical neoplasia is a spectrum of disease beginning with the cellular alterations of dysplasia, progressing to carcinoma in situ, and culminating in invasive cervical cancer (Figure 1). The histologic appearance is one of increasing cellular atypia, a disorderly arrangement of cells with loss of polarity and maturation, and frequent mitoses. The cells are characterized by hyperchromasia, nuclear pleomorphism, and changes in the nuclear/cytoplasmic ratio. As long as the cellular aberrations are confined to the epithelium, above the basement membrane, we can refer to it as "cervical intra-epithelial neoplasia." When less than 1/3 of the thickness of the epithelium is involved, it is called mild dysplasia; when <sup>2</sup>/<sub>3</sub> of the thickness is involved it is moderate dysplasia and full thickness changes characterize

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF SEPTEMBER, 1974.

Dr. Buchsbaum is an associate professor in the Department of Obstetrics and Gynecology at The University of Iowa College of Medicine. Dr. Davis is in private practice in Cedar Rapids, Iowa. Dr. Blythe is an American Cancer Society Clinical Fellow in Gynecologic Oncology.

### CERVICAL NEOPLASIA

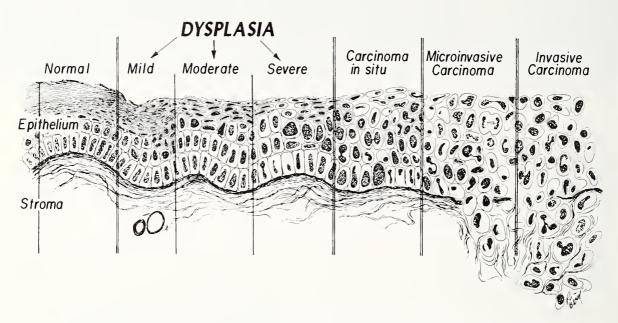


Figure 1.\* This illustration shows the progression of cervical neoplasia from normal to invasive carcinoma.

severe dysplasia. Carcinoma in situ involves the full thickness and the cellular changes are more marked, with frequent mitoses, and more extensive involvement of the epithelium (Figure 1).

When the abnormal epithelium breaks through the basement membrane into the underlying stroma, the condition is classified as invasive cervical carcinoma (Figure 1). "Micro-invasion" is a newer term that applies to the earlier stages of invasive carcinoma when the depth of involvement is less than 3 mm and there is continuity with the epithelium with the surface. If there is any lymphatic or blood vessel involvement, the disease must be classified as frankly invasive carcinoma. This distinction is important in selecting the appropriate operative procedure for treatment.

While most cases of invasive carcinoma progress through dysplasia and carcinoma in situ, not all cases of dysplasia or carcinoma in situ progress to invasive carcinoma. One cannot predict on a morphologic basis which cases will pro-

gress, but it is estimated that only 13% of mild dysplasias progress while 87% regress or persist. Approximately ½ of cases of severe dysplasia continue on to carcinoma in situ and invasive carcinoma.¹ In a different study, Richart and Barron² estimated the median transition time from severe dysplasia to carcinoma in situ to be 12 months.

While dysplasia, carcinoma in situ and invasive carcinoma often co-exist, the detection of dysplasia in a given population is approximately 3 to 5 years earlier, on the average, than the age of detection of carcinoma in situ. Carcinoma in situ, in turn, is detected approximately 13 years earlier than is invasive carcinoma. The age differences at detection, the findings of carcinoma in situ at the borders of invasive carcinoma, and the transition times in observed cases, suggest that they all represent stages in a single malignant process.

### CLINICAL

The single most important factor in the improved prognosis in cervical carcinoma has been the early detection of cervical neoplasia by the use of the Papanicolaou smear. It should be part

<sup>\*</sup>From Yannone, Michael E., and Buchsbaum, Herbert J.: GYNECOLOGY. In Liechty, Richard D., and Soper, Robert T.: SYNOPSIS OF SURGERY, Ed. 2, St. Louis, 1972, The C. V. Mosby Co. Used with permission.

of the physical examination of every woman. The Pap smear is essentially a superficial cellular biopsy that allows us to detect intra-epithelial and micro-invasive disease of the uterine cervix before it is evident on clinical examination. The smear is painless, inexpensive, accurate and easy to perform in the office. Every woman over 18 and those younger who have undertaken sexual activity—should have an annual Pap smear. The "once a year" rule is safe, but women at greater risk (e.g. early coitus, high parity, low socioeconomic group) should perhaps have more frequent smears. We have seen patients with invasive carcinoma as young as 16 and as old as 93. In the last 25 years at the University of Iowa Hospitals, we have treated 8 patients with invasive carcinoma of the cervix under 21 years of age. As the result of the changing social mores, cervical neoplasia is now detected at an earlier age. Fourteen of 657 (2.1%) women seen in our department at the University of Iowa Hospitals with carcinoma is situ of the uterine cervix were under 21 years of age.

We use an Ayer spatula to scrape the cervix and a cotton tip applicator to sample cells from the endocervical canal. In a hospital setting, ether-alcohol is an inexpensive and effective fixative for transportation of the slide to the cytopathology lab. An aerosal spray fixative which is commercially available is a convenient method for fixing slides in the office. Most local hospitals provide cytology services for interpretation of the smear. Or the smears, after fixing and drying, can be sent to a commercial laboratory. Some clinics utilize a cotton tipped applicator to also sample the vaginal pool. We alert our patients to the fact that the "Pap test" is effective for the detection of cervical carcinoma, but not for endometrial carcinoma, since approximately 40 to 50% of the cases of endometrial carcinoma are missed by the cervical Pap smear.

If the cervix appears smooth, clean and without any breaks in the epithelium or elevated lesions, and a normal Papanicolaou smear is obtained, the smear should be repeated at yearly intervals. If on the other hand, the report is returned as abnormal, additional studies must be undertaken (Figure 2). The diagnosis of cervical carcinoma cannot be made by cytology. It requires tissue confirmation by histological examination of a biopsy. If there is a visible lesion on the cervix, ulcerative or exophytic, a biopsy should be obtained. This can be done painlessly in the office with a punch biopsy. It does not re-

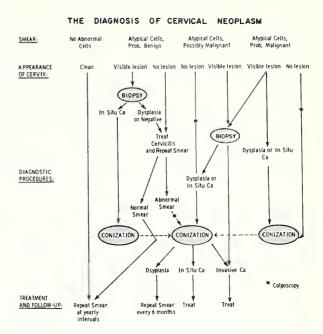


Figure 2.\* Shown in chart form are the diagnostic and treatment steps to be followed depending upon the evidence which is present.

quire any anesthesia. A variety of instruments are available and all serve the purpose. In the presence of a visible lesion, cervical cone biopsy (conization) is contra-indicated. It is never curative and requires the patient to be admitted to the hospital at considerable cost. She then needs an anesthetic, and is submitted to a 10% risk of bleeding severe enough to require transfusion. Even worse, cutting across tumor may hasten the vascular and lymphatic dissemination of this tumor.<sup>3</sup> Furthermore, parametritis frequently accompanies the healing at the conization site, necessitating delay in the institution of definitive therapy. In surveying the records of patients referred to us with Stages Ib, IIa and IIb cervical carcinoma for the years 1965 to 1970, we found that an average of 12% had conization in the presence of a visible lesion. In one of the years studied, the figure was 23%.

An abnormal smear in the presence of a normal appearing cervix is harder to deal with. Staining the cervix with Lugol's iodine (Schiller's stain) helps the physician select a site for biopsy. Abnormal epithelium fails to take up the stain while the rest of the cervix stains a dark brown

<sup>\*</sup>From Yannone, Michael E., and Buchsbaum, Herbert J.: GYNECOLOGY. In Liechty, Richard D., and Soper, Robert T.: SYNOPSIS OF SURGERY, Ed. 2, St. Louis, 1972, The C. V. Mosby Co. Used with permission.

or ebony. When there is no differential staining, the clinician is faced with the dilemma of where to biopsy. We do not advocate four quadrant punch biopsies. We feel that this is a "stab in the dark." Conization is a definitive diagnostic procedure.

Conization with its risks and hazards can often be avoided by the use of the colposcope. The colposcope is a piece of office equipment which allows the clinician to view the cervix under 10 to 14-fold magnification. There are colposcopically characteristic cellular and vascular changes of dysplasia, carcinoma in situ, and early micro-invasion. The colposcope allows the physician to direct his biopsy to the most abnormal site on the cervix (Figure 2). Sharp endocervical curettage should be part of the colposcopic examination, obtaining tissue from an area not visualized.

Colposcopic examination is particularly useful in the pregnant patient with an abnormal cervical smear. Pregnancy increases the hazard of bleeding following conization and there is the added risk of abortion or premature labor. The squamo-columnar junction of the cervix is everted during pregnancy allowing the examiner to completely visualize the transition zone and obviates

the need for endocervical curettage.

Depending on colposcopic appearance, the ability to visualize the transition zone, and the pathology report, one may quit at this point, or one may need to continue on to conization. In the hands of the experienced colposcopist, the directed punch biopsy and endocervical curettage can eliminate the need for hospitalization and conization, with its costs and risks, in over 80% of the cases.<sup>4</sup> This service is available to Iowa physicians at the Gynecology Clinic at the University of Iowa Hospitals.

Once the diagnosis of cervical neoplasia has been established, appropriate treatment can be started. In invasive cervical carcinoma, staging must be carried out by physical exam, roentgen and endoscopic examination before therapy is instituted.

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### Reflections on Colon Surgery

JAMES F. BISHOP, M.D.

Davenport

General observations, 23 in number, are presented based on the author's more than 900 operations on the colon. No attempt is made to provide detailed case data.

THERE FOLLOW HERE some ruminations based upon more than 900 personally done major operations upon the colon. They largely involved malignancies, diverticulitis, Crohn's disease, ulcerative colitis, procidentia, and colonic polyps.

- 1. The contents of a toxic megacolon are awesomely virulent. Once they escape into the peritoneal cavity, the outlook is quite dark. Excision of such a damaged colon should not be long delayed.
- 2. Unless the rectum is irrevocably damaged, its retention should be seriously considered at the time of colectomy for ulcerative colitis or Crohn's disease. Later ileo-proctostomy is often practical and bowel continuity can often be retained by judicious use of steroids and Azulfidine. The frequency of stools usually can be maintained within easily tolerable limits.
- 3. Since these diseases most commonly afflict the young, retention of the rectum is particularly desirable in the male where proctectomy all too often results in impotence.
- 4. Exacerbations of ileitis frequently respond to reasonable doses of steroids which may be discontinued when the attack subsides. Patients with persisting symptoms often can be kept comfortable and active with daily prednisone dosage in the 5-15 mg range.
  - 5. Anal lesions of ileitis are often painful and

slow to heal and their excision may leave tender, indolent wounds. Control of the ileitis with steroids encourages anal healing.

- 6. In the great majority of patients with ulcerative disease of the colon, the process is limited to the distal 12-15 cm and never ascends higher. It undergoes exacerbations and remissions, the latter often hard to come by, persisting largely as a nuisance and source of worry but rarely causing significant disability.
- 7. When draining the abscess of perforated diverticulitis, it is useful to remove the offending segment of bowel. This relieves the body of the task of contending with the necrotic, infected mass of tissue and establishes the diagnosis promptly. Carcinoma perforates sometimes, too, and subsequent treatment of the two diseases is quite different. The proximal divided end of bowel can be brought out as a LLQ colostomy and the distal end brought out or closed and dropped back. I lack the courage to carry out immediate anastomosis.
- 8. If the perforation mentioned above arises from diverticulitis, the patient and I resign ourselves to living with that colostomy for six months. During that period the pelvis tidies up remarkably, reducing the difficulty of the subsequent mobilization and anastomosis. If the lesion is carcinoma, the infected process must be confronted and wider resection carried out as soon as possible.
- 9. With an obstruction 15 cm or less above the anal outlet, the sigmoid is the location of choice for the relieving colostomy. The length of bowel requiring irrigation is quite short from colostomy to obstruction and the rest of the colon can evacuate itself. At the time of the definitive operation, the colostomy can be dealt with either by being converted to a permanent stoma or mobilized and resected with the excised bowel. This obviates

Dr. Bishop is in the private practice of medicine in Davenport, Iowa, and specializes in proctology and colon and rectal surgery.

a third procedure to eliminate a transverse colostomy.

- 10. Routine post-operative naso-gastric suction was abandoned many years ago. Seventy-five percent of colonic surgical patients do not need suction at any time. In those who ultimately require suction, it is not needed for the first 48 to 96 hours and often is necessary for only 24 to 48 hours. This would seem to argue that the routine decompressive gastrostomy recommended by some is usually unnecessary. Although a minimal one, gastrostomy is an added major procedure.
- 11. Post-operative ileus or obstruction? In the absence of cramping, the bowel inactivity is far more likely to be ileus which may persist for seven days or more. Here, gastric suction, supportive measures, and patience, usually pay off.
- 12. It probably matters little, within reason, what type of suture is used in an anastomosis so long as the joining pays respect to three cardinal requirements: a snug union without tension and with a demonstrably adequate blood supply. Any compromise invites necrosis and leakage with potential disaster.
- 13. Despite such care, anastomoses probably develop minor leaks, with spontaneous control, oftener than realized. Upon occasion, the usual post-operative ileus will subside and bowel activity resume for a day or two, then suddenly cease and ileus return. This is anastomotic leakage until proven otherwise. Gastric suction and supportive measures with watchful waiting may find the problem resolving itself. If not, proximal diverting colostomy will be imperative.
- 14. In anterior resections of the rectum with the anastomosis below the peritoneal reflection, I flee readily to the haven of a diverting transverse colostomy. To be truly diverting, the colostomy should be double barrel with a limb at either end of the upper right transverse incision.
- 15. To mature or not mature a permanent single barrel colostomy? Here I stand firmly upon indecision. I vacillate. The immediate maturing of such a stoma markedly reduces the danger of later stenosis at the skin line. However, eversion of the mucosa and suture to the skin margin often so embarrasses the circulation that the exteriorized length of bowel sloughs to the skin level or below. This disconcerting event then is followed by a few cases in which the chastened surgeon permits the stomata to mature on their own. Sooner or later there appears one with

- marked stenosis at the outlet and this starts the whole circle over again.
- 16. Scattered among these more than 900 operations upon the colon are some 450 people who had cancer between the cecum and the anus. Four hundred consecutive ones were scanned and 43 found to have had more than one bowel cancer. Some occurred together while others were separated by varying time intervals.
- 17. Many bowel cancers operated upon in hopes of a cure later re-appear. In the overwhelming majority of these, the recurrence made its presence known within two and a half years. Hence, I am increasingly reassured as the three year mark is passed—at the same time keeping watch for the occasional second cancer.
- 18. Even in the presence of distant metastases, the primary bowel neoplasm should be removed when at all reasonably possible. This applies even though abdomino-perineal resection is necessary. This relieves the patient of the ulcerated, debilitating lesion which may also be obstructing. There is little palliation in a colostomy that leaves behind a rectal neoplasm with its tenesmus and demanding sense of incomplete evacuation. Removal of a primary often seems to slow the growth of metastases and may result in the partial or total disappearance of associated polyps.
- 19. We have been trying pre-operative cobalt irradiation in the range of 4000-5000 rads in some rectal cancers. This can be a generally debilitating experience for the patient although he usually is recovered by the time of surgery some five to six weeks after completion of irradiation. Thus far, no surgical problems have been encountered that could be attributed to the emanations. In several, the lesion was markedly diminished in size and in one there was no microscopic evidence of neoplasm in the excised bowel. Where anastomosis is done to a rectal stump, there may be a troublesome irradiation proctitis with marked mucosal edema, ecchymoses and briskly bleeding granulations. Hydro-Cortisone enemas have been helpful in controlling the worst of the symptoms.
- 20. Bowel carcinoma metastasizes to liver and lungs rather frequently. Some among these showed spread to brain, bone, cervical nodes, and even a subcutaneous nodule. It is to wonder why metastasis to muscle has not been seen. Cancer cells in the circulation beyond the lungs that filter out in brain and bone must also be in the

blood circulating through muscle. What is there in muscle that is so hostile to circulating cancer cells and why is it such sterile soil for their growth?

21. A microscopic diagnosis of carcinoma in the large bowel does not require the same treatment in each case. Polyps, arising from the mucosal surface and separated from it by a stalk, even a short one, seldom exhibit the same virulent invasion and mestastasis expected from the annular or cauliflower neoplasms. Such lesions may frequently yield a microscopic diagnosis of carcinoma, yet experience, one's own and that reflected in the literature, suggests that these are not yet full blown cancers and need not be treated as such. Some years back when I received a microscopic diagnosis of carcinoma in this kind of lesion removed by snare from the lower sigmoid, I would respond by segmental resection of the involved bowel. After several instances, and without fail, of reports from the pathologist that no gross or microscopic evidence of residual neoplasm was found, I abandoned the resections. There have been numerous instances since wherein such lesions were excised with the snare and their bases fulgurated. Periodic observation over a number of years has failed to disclose a single instance of reappearance. This

approach to rectal polyps, sometimes rather large ones, has safely indulged the patient's sentimental attachment to his anal sphincters, an attachment which his surgeon would display toward his own. Admittedly, the selection of cases must be made very carefully. They are not included among the 450 cancer patients mentioned here.

22. Squamous cell carcinoma of the anus, not a common lesion, often seems more lethal than the glandular neoplasms above. Sometimes, however, they are well demarcated and localized and may be eradicated by simple, but generous, local excision.

23. The distressing anal incontinence that accompanies rectal procidentia does not seem to result from the telescoping of the bowel through the outlet with stretching of the sphincter. Several patients have been seen who had incontinence and loss of sphincter tone without prolapse and with only some bulging of the perineal musculature. Prolapse and procidentia appeared later.

The foregoing observations and conclusions do, indeed, stand somewhat naked and unsupported here by detailed presentation of cases. The documenting records are on file, however, and the positions taken will be defended with a modicum of spirit and vigor.

### Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

Sept. 4-5	Occupational and Environmental Health Prob- lems of Agricultural Workers	Sept. 26-27	Adopting a Keller-Type Caurse in Human Pa- thalogy to Fit the Curricular Needs af Health
Sept. 6-7	Iowa Chapter of American Academy of Oph-	5 . 0/ 00	Prafessions  Confinence Dell'article
	thalmology and Otalaryngology	Sept. 26-28	Canference an Pediatrics
Sept. 6-8	Medicine and Religion (Vocation-Avocation) (Lake Okoboji)	Sept. 27-28	Annual Meeting, Iowa Chapter of American Academy af Pediatrics
Sept. 9-13	Conference an Nuclear Medicine	Sept. 27-28	Dermatolagy far the Dermatalagist
Sept. 11	Fall Meeting of the Page Caunty Medical Soci-	Sept. 27-28	Annual Meeting, Iowa Dermatological Society
ety (Clarinda)		Sept. 27-28	Iowa Society af Anesthesiolagists
Sept. 11-14	Surgical Techniques in Cleft Lip and Palate	Oct. 4-5	Pastgraduate Conference an Urology
Sept. 13-15	Fourth Annual Dialogue for Physicians and Haspital Administrators (Spring Brook State	Oct. 4-5	Annual Meeting, Iowa Uralagical Society
	Park Conservation Education Center, Guthrie Center)	Oct. 7-11	Intensive Caurse in Pediatric Nutrition far Nu- tritionists and Dieticians
Sept. 19-21	Otolaryngology Alumni Reunion	Oct. 9	What's New in Stroke
Sept. 23-26	Cardiology Today	Oct. 11-12	The Evaluation and Management of Pain (Phys-
Sept. 25	Diet Therapy U.S.A.		ical Therapy)

### The Iowa 500: A Comprehensive Study Of Mania, Depression and Schizophrenia

JOHN CLANCY, M.D.,
MING-TSO TSUANG, M.D.,
BARBARA NORTON, MSW, and
GEORGE WINOKUR, M.D.
lowa City

Preparatory steps in an lowa research study of mania, depression and schizophrenia are outlined. Potential for separating out homogeneous syndromes is considered significant.

This paper will describe a large mental health research project now in process at the Psychopathic Hospital and the Department of Psychiatry at the University of Iowa. Two major psychoses, affective disorders and schizophrenia, are involved with emphasis on a follow-up study of patients and first degree relatives. The discussion includes a statement of objectives, feasibility, method of selection of the patient population and social and demographic characteristics of the research sample. Findings to date will be summarized, plans and methodology for follow-up will be presented and the significance of the study will be discussed.

### **OBJECTIVES**

The general objective is to collect data to advance our understanding of schizophrenia and affective disorders, particularly in relationship to diagnostic validity, clinical features, course, outcome and familial incidence. To assemble a suitable population for study 525 patients were se-

lected from inpatients consecutively admitted to the Iowa Psychopathic Hospital between 1934 and 1944. The patients were selected according to specific research criteria<sup>1</sup> for bipolar affective disorder (100 manics), unipolar affective disorder (225 depressives) and schizophrenia (200). The specific objectives of the study are (1) to follow-up all index patients whether living or dead, (2) to interview personally all living first degree relatives, residing in the State or within 300 miles of Iowa City, or in the near vicinity of any index patient.

To obtain comprehensive and standardized epidemiological data a structured interview form (Iowa Structured Psychiatric Interview) was designed specifically for the project. The interview of both patients and relatives will be conducted without knowledge of the patient's research diagnosis (blind interview). For comparative purposes 160 non-psychiatric control subjects have been selected from patients admitted to the University General Hospital during the same period. All control subjects and their first degree relatives will also be interviewed blindly.

Similar studies by investigators in this country and abroad have contained defects in methodology or design. The Iowa study, popularly known as "The Iowa 500," has been designed to minimize such defects. It contains a systematic evaluation of the clinical features and course of the illness, a blind family interview, combined with a study of control subjects from non-psychiatric patients and their family members. Data from such a study hold much potential for advancing our knowledge of affective disorders and schizophrenia. Substantial benefit will derive if we are able to single out specific homogeneous disease entities and develop a valid set of diagnoses in what now appears to be a very heterogeneous set of illnesses.

### FEASIBILITY OF STUDY

Aside from the objectives of the study, the question may be asked as to why this project is

The authors are associated with the Department of Psychiatry in the College of Medicine at The University of Iowa and with the Psychopathic Hospital, Iowa City. Dr. Clancy is professor, Dr. Tsuang is associate professor, Mrs. Norton is a psychiatric social worker, and Dr. Winokur is head of the Department and director of the Psychopathic Hospital. This project is supported by NIMH Grant No. 1 R01 MH 24189-01.

being conducted in Iowa and why this particular population has been chosen for follow-up study. A number of reasons support the conduct of such a study.

In the 1930's patients were admitted to the Psychopathic Hospital primarily for diagnostic purposes. The medical records were of an unusually high standard and very complete. They were written by psychiatrists who became quite distinguished in the field of psychiatry (Drs. A. Wood, T. Lindemann, W. Malamud, J. Gottlieb and A. Sahs). The records contained a psychiatric history, past medical history and a complete family history, with an itemization of parents, siblings and children as well as extended family members. Patients' current mental status, reports of laboratory studies and consultations, diagnosis, progress and treatment notes, discharge and final disposition were all recorded routinely. Social histories gathered by hospital social workers and reports from other hospitals and physicians supplemented the psychiatric record.

The patients under study were hospitalized during the depression years. Iowa was not part of the dust bowl, and the population was predominantly rural. It is unlikely that patients migrated outside the State, as the rest of the country would have offered no greater economic opportunity. This relatively stable population is ideal for the research.

To test the feasibility of this study, a small pilot project was undertaken. We attempted to locate the first 50 index patients. Forty-nine were located and information was available on the fiftieth which permitted follow-up for fifteen years past discharge. Eighteen (36% of the 50) were still living, and 14 (78% of the living) were still living within the State of Iowa. Based on these preliminary figures, it is estimated that 247 (35% of the total index patients and controls) are still living in and outside of the State. Assuming approximately three first-degree relatives per family of the total patients can be interviewed, we estimate there will be about 2,500 relatives to be interviewed.

### SELECTION & DESCRIPTION OF RESEARCH SUBJECTS

This large research project will require considerable personnel and adequate financial support. Federal funds have been obtained, and it is planned to complete the study within three years.

We have systematically reviewed the charts of

TABLE !

	Sch	izophrenic		Manic	De	pressive
N (525)	200		100	)	225	
		(51.5%)	38	(38%)	100	(44.4%)
Female	97	(48.5%)	62	(62%)	125	(55.6%)
Married	40	(20%)	51	(51%)	166	(74%)
Poor premorbid adjustment and						
work history	100	(50%)	5	(5%)	7	(3%)
High school grad.	56	(28%)	29	(29%)	54	(24%)
Suicide attempts with						
present illness	2	(1%)	5	(5%)	61	(27%)
Precipitating factors	22	(11%)	27	(27%)	88	(39%)
Age of onset						
(median)	25.9		26	.5	39.4	
Age at admission						
(median)	27.0		30.	.1	44.8	
III more than I year						
before admission	170	(85%)	11	(11%)	59	(26%)
Discharged to						
community	52	(26%)	39	(39%)	108	(48%)

the Iowa Psychopathic Hospital from 1934 to 1944 and have chosen subjects whose diagnosis meets the specific diagnostic research criteria published by Feighner et al.1 These diagnostic criteria have been sufficiently validated by precise clinical description, follow-up and family studies for use in research. While these criteria are not perfect, we believe we have collected homogeneous diagnostic groups. Many of the patients originally diagnosed as having either affective disorder or schizophrenia were discarded from the sample because they failed to satisfy research criteria. In the final sample it was found that of the schizophrenic patients selected there was chart agreement in 95% and in affective disorders there was a 93% agreement with the original chart diagnosis.<sup>2</sup>

The research population now consists of 525 index patients (probands): 200 schizophrenics, 100 manics (bipolar affective disorder) and 225 depressives (unipolar affective disorder). Social and demographic characteristics of this population and for each diagnostic category are presented in Table I. Because diagnostic criteria weigh heavily in favor of the presence or absence of certain social characteristics, only a limited number of statistical comparisons can be made validly.

Fifty-two of 200 schizophrenics (26%) were discharged to the community. However, 39 out of 100 manics (39%) were discharged to the community. If we take this parameter as one of the

criteria to assess the outcome, manics did better than schizophrenics (p, .050-.025). In the case of depressives, 108 out of 225 depressives (48%) were discharged to the community; apparently depressives did far better than schizophrenics (p < .0005). When we compared manics and depressives, there was no statistical significance (p, .20-.10).

Precipitating events prior to onset of illness were evident in 39% of depressive patients, and 27% of manics.<sup>3</sup> This difference is significant at the .05 level. In schizophrenics a precipitating factor was present in only 11% of patients, a significant difference from the manics (p < .01).

Eighty-five percent (170/200) of schizophrenics were ill for more than one year before the index admission. This proportion is far greater than 11% (11/100 of manics (p < .0005) and 26% (59/225) of depressives (p < .005). When manics were compared with depressives, 78% (78/100) of the former and 43% (97/225) of the latter were ill for three months or less before the index admission; the difference reaches statistical significance (p < .0005). Instead of being ill for three months, if we take one month or less before the index admission, 64% (64/100) of manics and 12% (27/225) of depressives were included in this category (p < .0005).

It is apparent from the data that the short term prognosis for depression or mania is better than for schizophrenia as measured by the number of patients discharged to the community. The outcome was determined in the absence of any specific treatment for either affective disorders or schizophrenia. In the 1930's electrotherapy was not yet in general use and the phenothiazines and antidepressant drugs were not discovered. Outpatient mental health programs were still undeveloped and a patient's return to the community was dependent on his improved mental status, rather than on any continuing outpatient treatment program. The etiology of mental illness was a mystery, and psychiatrists at the time adhered strongly to the organic or biological model of illness. Social factors were not given much weight as precipitants of mental illness. The presence of a precipitating factor related to onset of illness was, however, much more likely to be found in cases of affective disorder than in schizophrenia. Even so, precipitating factors were found in only 35% of the overall affective disorders (manics + depressives) included in this group.

### PLANS FOR FOLLOW-UP

To the 525 index patients a control group of 160 non-psychiatric patients has been added. This represents a stratified random sample of appendectomy and herniorrhaphy patients admitted to the University Hospitals during the same time period. We propose to study the control population in exactly the same way we will study the index patients. The criteria for case finding will be the same. Furthermore, blind interviews will be conducted on both the control and study groups to minimize the biases of the data obtained. Thus maximum comparability of the data from the two groups should be achieved.

A search will now be made for the index patients and the controls. As the cases are found, and if they are alive, each will be personally interviewed using the structured interview form. This will include an assessment of present status, psychiatric history and social history. Reliability exercises of applying the structured interview have already been completed. We are training residents, medical students and other personnel to use the Iowa Structured Psychiatric Interview. In the case of patients or controls who are no longer alive, all available hospital records and death certificates as well as physicians' reports and other documentation of the person's condition will be obtained. Based on these, the structured interview form will be completed insofar as is possible. This data will be reviewed by a principal investigator for final diagnosis and approval.

The same procedure of interviews will also apply in the investigation of family members. All first degree relatives still living in or within a three hundred mile radius of Iowa City, or in the near vicinity of any patient or control, will be interviewed personally. As it will be necessary to follow those who have migrated out of this area, we will make an effort to obtain all of the first degree relatives of any patient or control subject who live in the same area to which we must travel for an interview.

### SIGNIFICANCE OF STUDY

This research project deals specifically with the population of Iowa; there have been no psychiatric epidemiological studies based on the general population of this State. The major significance of this project is the potential for outlining homogeneous illnesses or syndromes within the general rubric of affective disorders and

(Please turn to page 398)

### Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

### **Training of Sales Representatives**

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce — information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

### Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

### The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

### The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

### Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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schizophrenia. There is already good evidence that affective disorders may be divided into bipolar and unipolar type. Schizophrenia has been considered by many to be a collection of more specific illnesses which have only a phenotypic resemblance to each other. By obtaining clinical material, follow-up material, and family constellation material, combined with those of controls, it may be possible to separate the specific kinds of schizophrenia. This would be of an enormous importance for further biological, psychological, or social studies.

Besides being the only large follow-up and family study ever to be done in a major psychosis in this State, the family study is unique in that it will be concerned not only with parents and siblings, but also with children. This opens up an entirely new set of possibilities, for the children will be almost totally through the age of risk, and therefore we will have a direct, non-derivative estimate of how much morbidity might be seen among them. Also, the morbidity risk of the families of index patients can be compared with those of controls. Whether or not having a psychiatrically ill relative will increase the morbidity risk is a matter of some importance in terms of ultimate management and intervention in families where the patients are suffering from affective disorders and schizophrenia. Thus there are many mental health implications to this study as well as implications for the question of heterogeneity or homogeneity in the affective disorders and schizophrenia.

The study also provides an opportunity for

residents and medical students to train in psychiatric research methods involving follow-up and family studies in the communities. Further they will become familiar in using comprehensive structured interview forms which cover nearly all aspects of psychiatric interviews, so they can apply the skills they obtain to their future clinical interview of patients.

### SUMMARY

The purpose of the study is to obtain objective data to aid in our understanding of mania, depression and schizophrenia. The project deals specifically with the population of Iowa. It contains a systematic evaluation of the clinical features, course of the illness, a blind family interview, combined with a study of control subjects from non-psychiatric patients and their family members. This report includes a statement of objectives, feasibility, method of selection of subjects and social and demographic characteristics of research sample. Plans for follow-up of subjects and relatives are described. The major significance of this project is the potential for separating out homogeneous syndromes within the general rubric of affective disorders and schizophrenia. This would be of importance for further biological, psychological or social studies.

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- 1. Feighner, J. P., et al: Diagnostic criteria for use in psy-
- chiatric research. Arch. Gen. Psychiat., 26:57, 1972.

  2. Morrison, J., et al: The Iowa 500: Diagnostic validity in mania, depression and schizophrenia. Arch. Gen. 27:457, 1972.
- 3. Clancy, J., et al: The Iowa 500: Precipitating factors in schizophrenia and primary affective disorder. Compr. Psychiat., 14:197, 1973.

### ADD 16,689 IN 1973

Another 16,689 licensed physicians were added to the U.S. medical profession in 1973—the largest increase in newly licensed physicians in any one year in the history of U.S. medicine.

The 15% increase over the number reported last year is in the 72nd annual report on medical licensure statistics by the AMA's Council on Medical Education. The report appears in the July 22 issue of Jama.

Of the 16,689 newly licensed physicians, 7,419, or almost half, were graduates of foreign medical schools, reflecting for the seventh consecutive

year a substantial increase in the number of foreign physicians taking state board examina-

As of December 31, 1973, there were 366,379 physicians in the United States. The total includes 326,933 licensed physicians, a net gain of 12,406 licensed physicians from the same date a year earlier, after physician losses due to deaths, retirements and return of foreign medical graduates to their homelands.

There were 2,213 more physicians receiving their first license in 1973 than in 1972. New York State had the greatest number of new physicians receiving their first license, 2,399.



M. E. ALBERTS, M.D., Scientific Editor

### ACUPUNCTURE—THE NEEDLE

The "legislative process" is depicted clearly in two articles which appear in the June 1974 issue of the western journal of medicine. The Governor of Nevada signed into law (on April 20, 1973) legislation which permits the practice of Chinese medicine, including acupuncture, as well as herbal medicine, by practitioners who do not have to be physicians. The article\* by Edwards provides a chronological story of how the bill came before the state legislature, and how the lawmakers eventually passed it. The article† by Anderson serves, in a way, as a catalyst to demonstrate the tactics used to get the legislation passed by a stampede vote (2 dissenters). The editorial emphasizes the rejection by the legislators of the offers of advice and consultation from the regular medical profession.

Edwards, W. M., Jr.: Acupuncture in Nevada. West. J. Med.,

120:507-512, June, 1974.

† Anderson, Fred M.: Instant acupuncture for Nevada—editorial. West. J. Med., 120:487-488, June, 1974.

### The later point is important. There is more and more interference with the profession of medical science as it delivers health care. I would be one of the first to admit that our profession is neither perfect nor above reproach. However, can a person outside the profession truly assess proper care if he has no knowledge other than hearsay and circumstantial evidence? Such testimony would be thrown out of a court of law; expert testimony would be demanded. Yet, the lawmakers seem often to resist expert testimony in deference to folklore and hearsay evidence. They, the legislators, become immediate experts.

It is to be hoped that any laws relative to medicine will be considered thoughtfully, rationally, and properly with a full ration of expert testimony. The same should hold for laws relating to any other profession or trade. Legislators are not omnipotent and knowledgable in all areas. Though their work may seem burdensome, their responsibility is, or should be, uppermost in their actions.—M.E.A.

### GOOD MEDICINE: GOOD MANNERS

An essay in the June 1974 issue of the JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION is worthy of mention because it deals with a situation close to all practicing physicians. Eric F. Geiger, M.D.\* writes of "avoiding referral mistakes: a function of good manners." He indicates that the dynamics of the referral process are complex, but the ethics of referral are not complicated because they are based entirely on thoughtful courtesy and good medical care. The physician must clearly understand his own role in order to communicate adequately with his colleagues as well as his patient. Should this fail his colleagues may no longer voluntarily refer patients to him or see patients for him.

Referral of a patient between two physicians involves four basic responsibilities: (1) request for the referral by the primary physician in a clear and concise manner so the consultant knows what is desired of him, (2) acknowledgement of the referral, (3) the furnishing of complete and accurate patient data, and (4) return of the patient to the primary physician. It is mandatory that the consultant be made aware of data al-

<sup>\*</sup> Geiger, E. F.: Avoiding referral mistakes: a function of good manners. J. Fla Med. Assn., 61:448-450, 1974.

ready available to avoid unnecessary repetition of diagnostic tests.

Common pitfalls involve both parties in the consultation process. The primary physician may be guilty of: (1) failure to state clearly the type of consultation desired, or (2) failure to forward valuable diagnostic data already available. The consultant, in turn, may (1) fail to determine the type of service desired and fail to acknowledge the referral, or (2) send inadequate reports to the primary physician, or (3) fail to return the patient to the primary physician after resolution of the problem prompting the referral, or (4) imply the previous care was poor, or (5) fail to notify the primary physician when a secondary consultation was requested (or fail to notify the secondary consultant regarding the primary physician).

Though most referral errors are unintentional

they are nevertheless thoughtless omissions. Good manners are important. Dr. Geiger points to the frequency of poor manners with in-hospital consultations wherein the primary physician shows little consideration for the consultant. The chart may be incomplete, no formal consultation request written, no history or physical examination recorded, and often the patient is not informed of the request for a consultation.

It is concluded in the discussion that the proper management of any referral, as in our relationships with any fellow physician or patient, one needs only to practice good medicine, maintain good communications and use good manners. Evaluation of one's self in this matter is incumbent upon all of us. Actually it is a good life-style in all our relationships with people—good manners, good communication, and practicing a good honest life.—M.E.A.

# It is our pleasure to serve as Administrators and Counselors for major Insurance Programs in behalf of the Members of many lowa Association Groups including:

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### DOUBT ACUPUNCTURE VALUE AFTER CHINA VISIT

WHILE STUDY of acupuncture to alleviate pain is important, use of acupuncture in an effort to cure human ills is dubious.

This conclusion was reached by an American Medical Association delegation following a three-week July visit to the People's Republic of China. The delegation was exposed to much traditional Chinese medicine, which includes acupuncture, cupping, moxibustion and herbal medicine.

In a prepared statement, the delegation acknowledged outstanding Chinese medical work in replantation of severed arms, legs, hands, feet, fingers and toes. It noted the favorable burn management, fracture treatment and venereal disease eradication. However, this initial statement by the AMA representatives was devoted primarily to acupuncture.

The statement acknowledges therapeutic acupuncture to be thousands of years old. It notes too the bewildering lack of uniformity in acupuncture practice. There are acknowledged acupuncturists in the Chinese schools of medicine, but 1.2 million "barefoot doctors" use acupuncture as well and teach it to worker, peasant and soldier families for their own use. The possibility for measuring acupuncture competence does not exist, the statement declares.

Said the American visitors to China: "Our observations would suggest that with that preponderance of self-limited patient problems which will generally respond to all manner of substitutes for scientific medical care, acupuncture and traditional medical measures will be equally successful. Recognizing that much of our modern pharmacopoeia has derived from past empiricism, it seems highly unlikely that traditional Chinese medicine may contribute additional therapeutic agents of importance. Evaluation should be encouraged under controlled circumstances. There is an undoubted advantage when traditional Chinese medicine is used in a population steeped in these traditions, ideologically saturated with them, and inherently confident in them. The virtues of traditional Chinese medicine would appear to be exportable to a very limited degree."

Acupuncture anesthesia is noted in the statement as being more correctly "hypalgesia"—a reduced perception of pain. Only about 15% of the major Chinese surgical cases employ it. It apparently is often combined with Western anesthetic agents. It is reported that acupuncture analgesia works best with a period of patient preconditioning by the anesthetist. This process is compared to hypnosis with acknowledgment that hypnosis is still an incompletely understood modality for pain control.

The statement reports some patients tolerate major surgery exceedingly well under acupuncture, alone or with minimal assisting measures. Others have a difficult time. In general, there is little muscle relaxation with acupuncture.

The three surgeons and one anesthesiologist in the 12-doctor group predict acupuncture analgesia will not be in heavy demand in this country. They refer to the lower pain thresholds of Eastern patients over their stoic Oriental brethren.

Two conclusions were noted by the delegation:

"1. It is the uniform opinion of the delegation that acupuncture analysia merits controlled experimental study. There is a need for continuing efforts to understand the nature of the acupuncture effect. Clinical studies of the applicability of acupuncture are undoubtedly in order and may perhaps best be carried out through cooperative ventures between accomplished Chinese practitioners of the art and licensed American physicians, dentists, and research scientists.

"2. It is the conviction of the delegation that acupuncture therapy should be regarded as the practice of medicine in an experimental phase, permissible only in qualified investigational settings. Every effort should be made to guard against the conversion of acupuncture into a new kind of quackery in the Western world. In China, acupuncture is not practiced for money. In our Western society, it should not become a technique for exploitation of the public."

### IN THE PUBLIC INTEREST

## The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

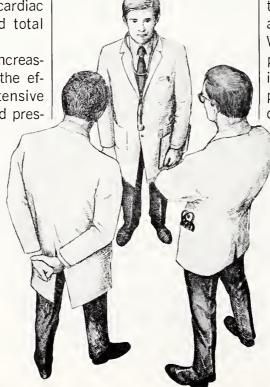
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pres-

sure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. Does it indeed help lower blood pressure effectively? Is peripheral resistance reduced? Are cardiac output and renal functions main-

tained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



## Educationally Speaking

by RICHARD M. CAPLAN, M.D.

### THE CONTINUING EDUCATION UNIT

A new concept has appeared on our horizon. You should know about it. It's called the "continuing education unit" (CEU).

For many years the "semester hour" has had a standard meaning to academic institutions, faculty and students—a meaning that permitted clarity of communication and transferability of credits from one institution to another. The world of continuing education had no counterpart either to certify quality or to keep records. But now a nationwide effort has defined the CEU as 10 contact hours of continuing education in a well-planned learning experience developed and offered by an appropriate educational institution. For example, 12 contact hours in a course designed for medical practitioners = 1.2 CEU.

On July 1, 1974 the University of Iowa began

Dr. Caplan is Assistant Dean, Continuing Medical Education at The U. of I. College of Medicine.

### IOWA MEDICAL MISCELLANY

RELATIONS . . . "Report on Physician-Hospital Relations—1974" was adopted by the AMA House of Delegates in June. Report contains 14 specific recommendations on problems involving hospitals and medical staffs. IMS legal counsel is preparing guidelines for Iowa physicians on this subject.

**CANCER CONTROL...** Members of IMS Committee on Oncology attended a July 24 meeting in Iowa City to discuss possibilities for a Cancer

to use the CEU and to perform the associated certification of quality of its offerings. At the same time, a related use of the computer began. All enrollments in continuing education, whether on or off-campus will be maintained on permanent record. The registrar's office will thus be able to provide a complete listing ("transcript") for all participations of any registrant, upon request of that registrant.

To use the computer, we need a ready numerical access provided easily by your social security number. So you'll find us asking for that number in our registration forms along with a small amount of additional demographic information. We'll appreciate your cooperation. You'll also find us seeking to be thorough in our enrollments for all of our learning offerings so that credit will be recorded where credit is due. As we approach an era of greater need for documentation of continuing education enrollments, these new services at the University of Iowa should prove helpful to you, the learner, as well as to us at the University.

Control Program in Iowa. George Jay, M.D., deputy director, Cancer Control Program, National Cancer Institute, participated in the session.

**APPOINTED . . .** Dennis D. Wilken, M.D., Osceola, has been appointed to the IMS Grievance Committee.

M & CH... Iowa Health Commissioner Norman Pawlewski and Immunization Director James Thompson met with the IMS Committee on Maternal and Child Health August 14 to review the status of communicable disease in the State.

### Morbidity Report for July, 1974

Disease	July 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties	Disease	July 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties
Adenovirus					Meningitis, type				
infection	ı	12		Des Moines	unspecified	4	21	13	Lee, Marion,
Amebiasis	6	20	15	Boone, Cedar, Linn					Pottawattamie
Ascariasis	- 1	6	4	Johnson	Meningitis,				
Brucellosis	3	11	4	Dubuque	aseptic	18	25	5	Polk
Chickenpox	61	6174	10767	Dubuque, Marion, Polk	Meningococcal				
Conjunctivitis	3	521	800	Johnson, Scott	meningitis	2	6	18	Lucas, Polk
Eaton's agent					Meningo-				
infection	2	25		Guthrie, Polk	encephalitis	- 1	2		Linn
ECHO 4 virus					Mumps	5	1611	3002	Des Moines, Polk, Scott
infection	3	3		Dickinson, Polk	Pediculosis	5	250	99	Dubuque, Linn
Gastrointestinal					Pertussis	2	9	18	Cherokee, Polk
viral infection	66	555 I	5278	Johnson, Marion	Pinworms	2	32		Polk
Giardiasis	9	32	10	Boone, Delaware,	Pneumonia	34	590	714	Scattered
				Humboldt, Jackson	Rabies in animal	s II	83	152	Scattered
Guillian-Barre					Ringworm, body	- 1	98		Linn
syndrome	3	7		Cerro Gordo, Polk	Rocky Mt.				
Hepatitis,					Spotted Fever	2	3	6	Des Moines, Linn
infectious	- 11	186	145	Scattered	Rubella	ī	15	197	Monroe
Hepatitis, serum	5	57	26	Clinton, Polk, Wapello, Washington	Rubeola	31	134	277	Dubuque, Pottawattamie, Scott
Hepatitis, type					Salmonellosis	23	107	92	Scattered
unspecified	3	23	9	Johnson, Polk, Sac	Scabies	4	56		Johnson, Polk, Washingto
Herpes simplex	П	65	38	Johnson, Keokuk, Lee, Webster	Shigellosis	16	112	173	Cedar, Dubuque, Linn, Story
Herpes zoster	3	27	9	Johnson, Jones, Linn	CI II				31019
Histoplasmosis	3	11		Buena Vista, Franklin, Jones	Streptococcal infections	363	7010	4550	Dubuque, Johnson,
Impetigo	- 1	195	205	Linn					Marshall, Polk
Infectious					Tuberculosis,				
mononucleosis	21	610	462	Johnson, Marion, Polk,	active	13	69	81	Scattered
				Scott	Venereal diseases	:			
Influenza-like					Gonorrhea	505	3492	3348	Black Hawk, Linn, Polk,
illness	38	8937I	11383	Buena Vista, Johnson, Linn,					Scott, Woodbury
				Polk	Syphilis	28	241	234	Scattered

### A NEW OPPORTUNITY FOR PHYSICIAN'S NURSES

The Department of Pediatrics and the College of Nursing at the University of Iowa have offered a Pediatric Nurse Practitioner (PNP) training course since 1972.

The 16-week course requires students to spend two days a week at the University receiving intensive training through lectures and first hand clinical experience. The students also spend two half days each week obtaining experience locally under supervision of their physician employer or preceptor. For acceptance, applicants must have RN status, some child health care experience and show an intent to use their training in the role of the PNP.

Specific PNP skills include: History taking and physical examinations, minor laboratory procedures, growth and development assessment, care for the newborn, counsel parents, recognition of and proper involvement in the management of the common childhood illnesses, etc.

This program is an attempt to help Iowa physicians provide excellent care to their patients. Comments or inquiries from interested physicians are welcomed and may be directed to the Department of Pediatrics at The U. of I. College of Medicine.

### Q & A ON KEY TOPICS

Q.: Is it necessary for non-licensed medical assistants to be named in the professional liability policies of their physician employers?

A.: Unlike the nurse-assistant, the medical assistant is not licensed and probably won't be for some time. A basic deterrent seems to be the definition of her duties. However, it is important for the physician's professional liability policy to contain a rider naming the medical assistants who are covered. They may be named in a malpractice suit.

Q.: How important is it to record cancelled appointments made via telephone?

A.: Legally, when a telephone call is received from a patient for an appointment, a contract is created even though no money has changed hands and the patient has yet to see the physician. NEVER erase a cancelled appointment, simply place a red "C" through or adjacent to the name of the patient. Then, on the patient's chart, enter the date of the appointment and a failure to show notation with the cancellation information, and initial. Be sure to state the reason for the cancellation.

Q.: What liability can be incurred in giving out information about a patient and his health record?

A.: Medical assistants become liable for invasion of privacy by releasing patient information without a current written consent from the patient. You are liable for defamation of character if you talk about a patient and his health record, so refrain from discussing any patient at any time.

**Q.:** How long should medical records be retained?

A.: The American Medical Record Association adopted a 1973 statement on the preservation of medical records of patients in health care in-

stitutions. This statement was also adopted by the Board of Trustees of the American Hospital Association. It recommends that complete patient medical records be retained either in original or reproduced form for 10 years after the most recent patient usage. After this period, such records may be destroyed unless destruction is specifically prohibited by statute, ordinance, regulation or law, provided the institution retains basic information, such as dates of admission and discharge, names of responsible physicians, record of diagnoses and operations, operative reports, pathological reports and discharge summaries for all records so destroyed.

Q.: Does this apply to all records?

A.: There is a distinction on medical records of minors. These must be retained for the time of minority plus the applicable statute of limitations in the respective states. Complete medical records of patients under mental disability must be retained in like manner.

Q.: Are there any other regulations governing the retention of medical records as recommended by AMRA?

A.: Records should be retained for longer periods when such a request is made in writing by an attending or consultant physician, the patient, or someone acting legally in his behalf, or legal counsel for a party having an interest affected by patient medical records.

Q.: How do you have a positive attitude?

A.: If one looks for the good things in the people you work for and with, it will be easier to like them and vice-versa. If you look for the good things in your office, and think positive, you will act positive. Consider the factors that make it a good place to work—of course, you should not avoid those negative elements that need to be changed. A positive person is not a weak person.

### About IOWA Physicians

Sioux City physicians—Drs. Dou E. Boyle, Horst Blume, Carleton Helseth, Richard Satterfield, E. L. Van Bramer, LeRoy Ayers, David Paulsrud, Stuart Leafstedt, Paul Fee, Barry Knapp, O. E. Selander and D. Schenk, participated in an Emergency Medicine '74 Conference in South Sioux City, Nebraska.... Dr. Thomas Frederick Viner joined his father, Dr. Thomas R. Viner, and Dr. Thomas R. McMillan and Dr. Phillip J. Sullivan in the family practice of medicine at the Leon Clinic in July. Dr. Viner received the M.D. degree at U. of I. College of Medicine and interned at University of Hawaii. Dr. Viner also studied acupuncture for one month in Taiwan.

Dr. Peter D. Wallace recently opened a private pediatric practice in Iowa City. Dr. Wallace is a 1969 graduate of U. of I. College of Medicine. He was certified by American Board of Pediatrics last spring following three-year residency at University Hospitals. . . . Dr. Francis Pisney, former Lime Springs resident, began a two-year tour of duty in June with the National Health Service Corps at Martin, South Dakota. Dr. Pisney received the M.D. degree at U. of I. College of Medicine in 1971. His additional training in family practice was at Ball Memorial Hospital in Muncie, Indiana. . . . Dr. Maurice Van Allen is new head of the Neurology Department at U. of I. College of Medicine. Dr. Van Allen, a faculty member since 1952, succeeds Dr. Adolph Sahs.

Mrs. Max E. Olsen, wife of Dr. M. E. Olsen, Minden, was elected North Central Regional vice president of Woman's Auxiliary to the American Medical Association at recent annual meeting in Chicago. Mrs. Olsen was president of Pottawattamie County Auxiliary in 1971-1972 and president of Woman's Auxiliary of Iowa Medical Society in 1967-1968. . . . Dr. Larry D. Beaty has

joined Drs. C. R. Sokol and Ray Robinson in family practice in State Center. Dr. Beaty, formerly of Marshalltown, recently completed his internship at Conemaugh Valley Memorial Hospital in Johnstown, Pa. . . . Dr. David Weinstein, Cherokee, has left the Cherokee Mental Health Institute to become medical director at the Polk County Mental Health Center in Des Moines. Dr. Weinstein completed his psychiatric residency at CMHI and has been on the staff for a year. . . . Dr. Robert Smits located his private practice in July at the Des Moines Medical Center. His solo practice will be limited to ear, nose and throat, facial plastic surgery and neck surgery. . . . Dr. Thomas E. Corcoran has been named chief of staff at Veterans Administration Hospital in Des Moines. Dr. Corcoran has been chief of laboratory service and has also served as acting chief of staff and associate chief of staff. A graduate of U. of I. College of Medicine, he has been associated with the VA Hospital since 1958.

Dr. Michael Abrams, Director, Emergency Department, Broadlawns-Polk County Hospital, Des Moines, and Dr. Charles Hartford, Director, Burn Unit, University Hospitals, Iowa City, were speakers at recent Second Annual Iowa Trauma Seminar in Waterloo. The event was cosponsored by Iowa Trauma Seminar Planning Committee, Iowa State Department of Health Emergency Medical Services Section, Iowa Committee on Trauma-American College of Surgeons and Hawkeye Institute of Technology. . . . Dr. John Addy has joined Drs. R. L. Wicks, W. E. Rouse, J. R. Anderson and J. F. Murphy in medical practice in Boone. A native of Adel, Dr. Addy is a 1971 graduate of The U. of I. College of Medicine and interned in Fresno, California. He was an Air Force flight surgeon for two years. . . . Dr. S. W. Barnett, a Cedar Falls physician for 50 years, entered semi-retirement in mid-June. Dr. Barnett is a 1923 graduate of the Northwestern University School of Medicine and had postgraduate training at St. Luke's Hospital in Chicago, Illinois. Dr. Barnett has written a book recounting his 50 years in medicine. The new book is called Unseen Battles of the Night, and is published by Congdon Printing Company in Cedar Falls. Dr. Barnett was honored July 14 at a special celebration in Cedar Falls Sartori Hospital cafeteria.

Dr. James Bullard, Decorah, has been recognized as 1973-74 "Outstanding Ski Patroller" in the 3-I Region. The 3-I Region is part of the National Ski Patrol System and includes all of Iowa, Illinois and Indiana and parts of Wisconsin, Minnesota and Michigan. Dr. Bullard was cited for his patrol system involvement not only in Decorah, where he helped organize local ski patrol, but also for his service as regional medical advisor. . . . The following Waterloo physicians were program participants in second annual "Triage in Trauma" conference in Waterloo—Drs. Lewis Harned, Francis Coyle, Robert Hathaway, Robert Soll, Robert Weyhrauch and David E. Brandt. The seminar was designed for Emergency Medical Technicians (EMT's) and prospective EMT's, physicians, nurses, law officers, firemen, civil defense personnel, safety engineers and other health care personnel. . . . Dr. David M. Paul, clinical associate professor, U. of I. College of Medicine, has accepted a position on St. Luke's Methodist Hospital medical staff in Cedar Rapids and will direct electromyography services. Dr. Paul recently retired as chief of physical medicine at VA Hospital in Iowa City.

Dr. Carl Vander Kooi, has joined his brother, Dr. Paul Vander Kooi, at the Orange City Medical Clinic. Dr. Vander Kooi recently completed a family practice residency at U. of I. College of Medicine. . . . Dr. David Bakken has entered family practice with Decorah Medical Associates. A native of Ridgeway, Dr. Bakken received the M.D. degree at U. of I. College of Medicine and interned at Bethesda Naval Hospital in Bethesda, Maryland, Dr. Bakken recently completed three years as a medical officer in the Navy. . . . Dr. Richard A. Frankhauser began family practice at Medical Associates in Cedar Falls in July. A native of Dysart, Dr. Frankhauser received the M.D. degree at U. of I. College of Medicine and interned at Marion County General Hospital in Indiana. He recently completed two years of duty with the Public Health Service in Langdon, N. D.

### **DEATHS**

Dr. John T. Strawn, 93, died July 21 at Meth-Wick Manor in Cedar Rapids. A graduate of University of Chicago and Rush Medical College, Dr. Strawn interned at Monroe Street and Presbyterian Hospitals in Chicago. Prior to his retirement in 1953, Dr. Strawn had practiced internal medicine in Des Moines for 43 years and from 1911-1913 was also an instructor of internal medicine at Drake Medical College. Dr. Strawn was a Life Trustee of Cornell College at Mt. Vernon and a Life Member of Iowa Medical Society and American Medical Association.

Dr. Francis W. Morgan, 51, died at University Hospitals in Iowa City following a short illness. Dr. Morgan received the M.D. degree at the University of Nebraska School of Medicine in 1949, and served his internship in Tacoma, Washington and his residency in obstetrics and gynecology at Chattanooga, Tennessee. He entered private practice in Ottumwa in 1952. Dr. Morgan was a past president of Wapello County Medical Society, member of Iowa Medical Society and American Medical Association.

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GENERAL PRACTITIONER NEEDED: Practice with complete freedom of action in a rural atmosphere? Office next to pharmacy, ready for occupancy, no unseen strings. Moville, Iowa, 15 miles east of Sioux City offers just such a chance. Contact Moville Community Development Association, Inc., Moville, Iowa.

IMMEDIATE OPENING for Ob-Gyn and Internal Medicine, specialties to establish successful practice with 14-man multispecialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

WANTED—FAMILY PRACTITIONER to associate with clinic group in northcentral Iowa, Community of 32,000. Excellent salary with planned time off. Replies confidential. Write No. 1497, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

ANESTHESIOLOGIST (M.D.)—Sec. Chief, Bd. cert., salary depending quals., modern 362-bcd univ. affil. hosp., own residencies gcn. surg. and nrol., full fringes, nondiscrimination in employment. L. T Palumbo, M.D., VA Hosp., Des Moines, lowa 50210

FAMILY PRACTITIONER—WANTED TO JOIN SMALL PROGRESSIVE GROUP serving beautiful Mille Lacs Lake area, only eighty miles north of Minneapolis; modern clinic and JCAH 73-bed hospital and ECF; excellent income; group support; two out of three weekends off; away from the madding crowd; yet not too far away; good schools; clean, uncrowded environment; lakes to live on; unfettered living; we need you. Contact Dr. Dennis R. Jacobson, 612-532-3113 (clinic), 612-532-3628 (home), or Marshall Engstrom, Hospital Administrator, 612-532-3154 (office), 612-532-3693 (home).

PHYSICIAN FOR STUDENT HEALTH SERVICE—Attractive small midwest town with excellent University of 20,000 students. New performing center attracts nationally prominent performing artists, Salary negotiable, Excellent fringe benefits. Contact J. II. Gardner, M.D., Director, Student Health Service, Iowa State University, Ames, Iowa 50010. Phone 515/294-5801.

GENERAL SURGERY (M.D.)—Asst. Chief, Bd. cert., interested in teaching, research and surg. administration, exp. thoracic—vascular surg., salary accord. quals. modern 362-bed univ. affil. hosp., own residency, modern animal rcs. lab., fringe benefits, nondiscrimination in employment. L. T. Palumbo, M.D., VA Hosp., Dcs Moines, Iowa 50310.

FAMILY PHYSICIANS—unique practice opportunity in an incorporated 28-man group in east central Wisconsin. New clinic facility across the street from 450-bed hospital. Idea cultural and recreational setting. Opportunity to develop special interests in acute and ongoing adult care and/or industrial

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PHASING OUT PRACTICE—FOLLOWING FOR SALE—BEST OFFER—One 30 MA. Kelly-Koett X-ray-Bucky table, Ben Morgan Ether-suction machine, Emerson resuscitator, Jones basal metalealomater, Brown-Buerger cystocope with ureteral catherization, Miller surgical knife and cautery, good Aloe office examining table, Webster procto, table, AO projectochart, office fire files, desks, inst. cabinets, etc. Write H. E. Stroy, M.D., Osceola, Iowa 50213.

VACANCY—ADMITTING, PRIMARY CARE, PERSONNEL PHY-SICIAN. Desire physician interested in academic university affiliation, preferably board certified in family practice. Five day week, nights frec. VA benefits and retirement. Salary \$26,000 to \$32,000 depending on qualifications. Nondiscrimination in employment. Inquire: Chief of Ambulatory Care, VA Hospital, Iowa City, Iowa 52240. Phone 319/338-0581.

WANTED—GP/FAMILY PRACTITIONER in Council Bluffs, Iowa. SALARY, \$40,000. After 2 years, if agreed by both parties, FULL PARTNERSHIP. GROSS in 1973, \$150,000. PRODUCTIVITY INCENTIVE—Desire sabbatical for 2 years. Write or call J. V. G. Angel, M.D., 1705 McPhersen, Council Bluffs, Iowa 51501. Call 712/328-2231, office or 712/324-1443, residence.

ADAPT, INC., drug treatment center in Des Moines, is seeking the services of full time medical director to act as physician for methadone treatment program, residential therapeutic community and free clinic, Salary negotiable, Contact R. Dennis Bowers, Executive Director, ADAPT, INC., 512 9th Street, Des Moines, Iowa 50309 or phone 515/288-9777 for more information.

GENERAL PRACTITIONER—Geriatric interest—Psychiatric Hospital. Liberal fringe bnefits. Near recreation areas and State Capital. Beginning salary \$25,863 to \$30,147 depending on qualifications, Internship, U. S. citizen and licensure required. Equal opportunity employer. Contact Louis Jensen, M.D., VA Hospital, Knoxville, Iowa 50138.

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### respond to one

According to her major mptoms, she is a psychoneutic patient with severe ixiety. But according to the scription she gives of her elings, part of the problem ay sound like depression. nis is because her problem, though primarily one of exssive anxiety, is often accomnied by depressive symptomology. Valium (diazepam) n provide relief for both—as excessive anxiety is reved, the depressive sympms associated with it are also ten relieved.

There are other advanges in using Valium for the anagement of psychoneutic anxiety with secondary pressive symptoms: the ychotherapeutic effect of alium is pronounced and pid. This means that imovement is usually apparent the patient within a few ys rather than in a week or

two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An h.s. dose added to the b.i.d. or t.i.d. treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, et al: Dis Nerv Syst 30:675-679, Oct 1969.

2. Hollister LE, et al: Arch Gen Psychiatry 24:273-278, Mar 1971.

3. Claghorn J: Psychosomatics 11:438-441, Sept-Oct 1970.



in psychoneurotic anxiety states with associated depressive symptoms

rveillance because of their predisposing to habituation and dependence. In agnancy, lactation or women of childaring age, weigh potential benefit ainst possible hazard.

ecautions: If combined with other psyotropics or anticonvulsants, consider refully pharmacology of agents emyed; drugs such as phenothiazines, rcotics, barbiturates, MAO inhibitors d other antidepressants may potentiate action. Usual precautions indicated in tients severely depressed, or with latent pression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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## President's Page

Certainly all Society members are intensely interested in what congress and the administration will do about national health insurance, either in 1974, 1975, or at the latest, by the 1976 elections.

Politicians and social planners get busy before each election. They try to attract votes by urging spending on their various projects. They think more and more strongly that they can take money from the public treasury and spend it more wisely than the people can on their own.

Since these actions bear on our patients' lives and our own, it is my belief we should all allot some time and effort to influence the votes and actions of our legislators. Now is the time to assess candidate thinking because the November election involves all our congressmen and one senator.



Let's get busy with our colleagues and support candidates who show fiscal responsibility and sound judgment. Your influence is enhanced not only by conveying your thoughts to a candidate, but also by a contribution to his campaign. The IMPAC Board members are informed and will help you with details.

I note Donald Kaul thinks President Ford must be all right since he carries his own briefcase. But Kaul adds there is "little" suggestion of greatness in his congressional record. I would differ with Kaul on this but my proclamation here will reach far fewer eyes.

One wonders at the advisability of government accepting more responsibility in an NHI program where costs are unknown, particularly when the country's economic status, and especially the government's, is already in sad, sad straits.

Sincerely,

Ralph L. Wicks

Ralph L. Wicks, President

## IOWA Medical Miscellany

ELECTION INFO . . . 25 Senate and all 100 House seats in the Iowa General Assembly are to be filled in next month's election. Physician participation in the election process is important. The November election will have a strong bearing on what health care proposals will receive priority attention.

ALCOHOLISM . . . Representatives of IMS Committees on Alcoholism and Psychiatric Care met September 5 with new acting director of State Alcoholism Division, Juris Poncius, to discuss new Iowa law which seeks to decriminalize alcoholism. Problems associated with law's early implementation were reviewed.

NURSING HOMES . . . Representatives of the State Departments of Health and Social Services briefed IMS Committee on Medical Care in Health Facilities and Homes September 19 on status of current programs relating to nursing home operations.

LEARNING MATERIALS . . . New medical instructional materials will be developed at the U. of I. College of Medicine under three-year \$210,000 grant from the Louis W. and Maud Hill Family Foundation. Objective will be to improve quality of medical education and contain costs. L. D. Holloway, Ed.D., will direct the project. Radiology, nutrition and pediatric ambulatory care will be initial subject areas covered.

KEOGH BOOST . . . Iowa physicians may increase Keogh-plan retirement contributions for this year to 15% of income, up to \$7,500. Liberalization of program is result of law enacted recently to place self-employed physicians in a more equitable tax status with retirement savings programs embodied in most corporate pension plans.

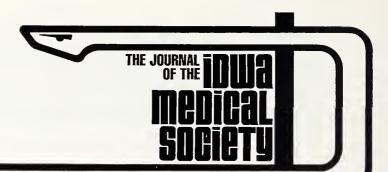
MOVING FORWARD . . . Efforts to activate the Student Iowa Medical Society are proceeding with Senior Jim Jensen and Sophomore Craig Trost providing leadership. Authority for IMS student component was given by the 1970 Hcuse of Delegates.

EXCEEDED QUOTA . . . For second year, IMS Woman's Auxiliary has exceeded \$10 per capita quota for AMA-ERF. In 1972-73 per capita of \$10.75 was achieved; in 1973-74, this was increased to \$11.64. Of the \$15,277.52 contributed in 1973-74, \$13,355.67 was earmarked specifically by the donors for the U. of I. College of Medicine. The total sum was presented to the U. of I. in April. The WA-IMS is grateful to Iowa physicians for their support of the AMA-ERF program.

NOVEMBER MEETING . . . IMS and Iowa Hospital Association will co-sponsor a TAP institute November 8 and 9 in Des Moines at The Hyatt House. Institute is presented by the Joint Commission on Accreditation of Hospitals and is for hospital trustees and administrators and physicians (TAP). Emphasis will be on quality assurance and review. Session is open to all interested physicians; all hospital medical staffs are being contacted.

REPORT ACKNOWLEDGED . . . Nolan H. Ellandson, Director, Division of Correctional Institutions, State Department of Social Services, has indicated report received from IMS Committee on Health Care in Correctional Institutions will be used as possible by the Division. Report was approved by the 1974 House of Delegates and was based on committee field trips to the four state correctional institutions.

(Please turn to page 439)



VOL 64 No. 10 OCTOBER, 1974

TABLE OF CONTENTS		SPECIAL DEPARTMENTS	
Multiple Myeloma in Iowa Manuel N. Callis, M.D., and Raymond F. Sheets, M.D.  Acute Bacterial Endocarditis With Septic Emboli Ching L. Chiu, M.D., and James D. Roelofs, M.D.  The Battered Child Harold A. Young, J.D.	429 434 438	President's Page Iowa Medical Miscellany State Department of Health Educationally Speaking In the Public Interest The Question Box Medical Assistants About Iowa Physicians Deaths	421 423 425 426 427 443 445
EDITORIALS  Immunization Action Month—1974  Self-Evaluation Programs	441 442	MISCELLANEOUS  Continuing Education Courses and Conferences  Antibiotics and Infection Conference in October	425 442

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# State Department of Health

# SECOND ANNUAL IMMUNIZATION ACTION MONTH

October has again been proclaimed "Immunization Action Month" in Iowa. The 1974 campaign is a month-long effort to educate and motivate all Iowa parents to obtain preventive vaccines for their children. Immunization Action Month is national in scope and is coordinated by the Center for Disease Control in Atlanta, Georgia.

More than 90% of Iowa infants currently receive three doses of DPT and two doses of oral polio vaccine before the second birthday. Paralytic polio has been reduced from 3,564 cases in 1952 to 0 cases in 1973; smallpox has been totally eradicated since 1948; Iowa has not had a confirmed reported case of diphtheria since 1968.

Unfortunately, outbreaks of rubeola were reported among several Iowa elementary schools this year as well as during 1972 and 1973. A survey of kindergarten children in September, 1973, identified approximately 25% of these children who, parents maintained, had not received the vaccine to prevent rubeola. Among kindergarteners in 1973, 85% reported 3 or more DPT, 70% had 3 or more polio, and 70% reported rubella immunizations.

In May the Iowa Medical Society House of Delegates approved a joint IMS-Iowa State Health Department statement which urges effort to bring about the practical eradication of diphtheria, pertussis, tetanus, poliomyelitis, rubeola and rubella. Following this, an Iowa Immunization Action Advisory Committee was formed with representation from the Iowa Medical Society, the Iowa Society of Osteopathic Physicians and Surgeons, the Iowa Academy of Family Physicians, the Iowa Chapter of the American Academy of Pediatrics and a host of other health and medical organizations. The charge of this advisory group is to design and implement an educa-

tional program to support the overall effort to accomplish practical eradication. Pointing the national Immunization Action Month activity toward this goal in Iowa during October, the committee is arranging for newspaper, radio and television attention to the subject of immunization.

The Woman's Auxiliary to the Iowa Medical Society has arranged for the distribution of posters and pamphlets on immunization. Newsletters, bulletins and formal articles are being circulated and presented in various health publications on the subject of immunization. Related organizations—the Iowa Pharmaceutical Association, the Department of Public Instruction, Iowa Educational Broadcasting Network, the Office of Comprehensive Health Planning—are initiating various activities in support of Immunization Action Month and the broad effort to make Iowa the "First State to Eradicate."

The fact that Iowa can begin to talk about eradication as opposed to control should dramatically demonstrate that a substantial majority of Iowa infants are already obtaining their necessary immunizations. The cooperative efforts of these highly respected agencies should help us to get at the remaining "hard to reach" group, which is still large enough to sustain recognized outbreaks of measles.

The 1974 Immunization Action Month in Iowa may be viewed as a "beginning to the end" of these childhood diseases which are preventable by immunization. The Iowa State Department of Health has added two additional immunization specialists to its field staff, they are serving out of Keokuk and Manchester.

The Iowa Medical Society Committee on Maternal and Child Health has pledged further active participation in an eradication campaign. Working effectively, we can jointly assure that Iowa is the "First State to Eradicate" diphtheria, pertussis, tetanus, polio, rubella, and rubeola.

## Morbidity Report for August 1974

Disease	Aug. 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties	Disease	Aug. 1974	1974 to Date	1973 to Date	Most Cases Reported From These Counties
Adenovirus					Influenza-like				
infection	I	13		Decatur	illness	76	89447	11385	Buena Vista, Johnson,
Amebiasis	6	26	54	Boone, Johnson, Polk, Ta-					Marion, Polk
				ma	Malaria, importe	d,			
Ascariasis	3	9		Johnson, Muscatine	P. folciporum	ı	1		Scott
Brucellosis	- 1	12		Dubuque	Meningitis, asept	tic 17	42	9	Black Hawk, Keokuk, Palo
Chickenpox	18	6192	10781	Dubuque, Lee, Polk, Scott					Alto, Polk
Combined					Meningitis, type				
infestations	I	1		Muscatine	unspecified	6	27	16	Lee, Marion, Sac, Scott,
Conjunctivitis	8	529	810	Henry, Johnson, Lee, Polk,					Sioux
				Wright	Meningitis,				
Cytomegalovirus	;				pneumococcal	1	2	3	Linn
infection	1	29		Webster	Meningitis, asept	tic			
Eaton's agent					assoc. with Ecl	ho-			
infection	2	27		Johnson, Muscatine	virus type 4	8	9		Cerro Gordo, Marion,
Echovirus type	4 7	10		Polk	**				Polk, Story
Encephalitis, vii	al 2	13		Black Hawk, Jackson	Meningitis, asept	tic			,
Encephalitis, vira				•	assoc. with Co				
assoc. with Ec					sackie B4	- 1	1		Polk
virus type 4	3	3		Dubuque, Polk	Mumps	6	1617	3010	Des Moines, Dubuque,
Enteropathogeni		•		- 4		-			Scott, Union
E. Coli	2	10	6	Wapello, Winnebago	Pertussis	3	12		Des Moines, Polk
Erythema	_			apana, minosago	Pinworms	9	41	6	Johnson, Polk
infectiosum	2	513		Carroll, Poweshiek	Pneumonia	42	632	775	Scattered
Gastroenteritis		0.5			Rabies in		002		200110102
to Vibrio	140				Animals	15	98	164	Cerro Gordo, Chickasaw,
parahoemolyt	icus 1			Woodbury	, (((((((((((((((((((((((((((((((((((((		,,		Dubuque Ombuque
Gastrointestinal					Rheumatic fever	. 1	42	15	Poweshiek
viral inf.	76	5627	5325	Johnson, Linn, Marion	Roseola	i	9		Muscatine
Giardiasis	3	35	13	Humboldt, Iowa, Musca-	Salmonellosis	19	125	114	
Ciardiasis	,	33	13	tine	Scabies	4	60	,,,	Johnson, Muscatine
Guillian-Barre				Time	Shigellosis	76	188	192	Dubuque, Jackson, Polk,
syndrome	1	8	4	Johnson	Singeriosis	,,	100	172	Scott
Hepatitis, A	•		7	3011113011	Streptococcal				36011
(Infectious)	12	198	160	Johnson, Muscatine	infections	283	7293	4745	Johnson, Keokuk, Polk,
Hepatitis, B	12	170	100	Comison, Muscamile	illections	203	1213	7/73	Washington
(Serum)	,	,,	2.1	Fayette, Madison, Polk	Tapeworm	1	1		Bremer
Hepatitis, type	6	63	31	rayerie, Madison, Fork		2	6		Buchanan, Muscatine
unspecified		24	1.4	S11	Toxoplasmosis Tuberculosis,	2	0		buchanan, Muscatine
		24	14	Scott		12	02	00	Di al Maria Des Maines
Hepatitis, non-		70	40	Polk	active	13	82	89	Black Hawk, Des Moines,
Herpes simplex	13	78	43	Black Hawk, Johnson,	Tubosculasia				Polk
<b>U</b>	_	2.2		Linn, Louisa, Polk	Tuberculosis, inactive	1		17	Callan
Herpes zoster	3	30	12	Johnson, Muscatine, Scott	Venereal Disease		9	17	Cedar
Histoplasmosis	1	12	8	Washington Dubusus Jahanna			2002	4050	Disab Manda Itan Dalla
Impetigo	3	198	210	Dubuque, Johnson	Gonorrhea	490	3982	4058	Black Hawk, Linn, Polk,
Infectious				D. 1. C. 1. 1. 1.	C1 *11*		0/0	274	Scott
Mononucleosi	s 32	642	476	Butler, Grundy, Johnson,	Syphilis	27	268	274	
				Marion, Scott	Whipworm	- 1	2		Muscatine



by RICHARD M. CAPLAN, M.D.

# DO YOU TEACH YOUR PATIENTS WELL?

In a medical world of increased complexity, with more emphasis on preventive care, risk factors in illness, long term management of chronic disorders, drug interactions, significant side effects of potent medications—it is more necessary than ever that physicians do an effective job of teaching their patients.

The role of the enlightened patient in helping wisely to care for himself can no longer remain unnoticed or unexploited. Perhaps we never ignored the patient's role but only made the unfortunately false assumption that he would indeed

Dr. Caplan is Associate Dean, Continuing Medical Education at The U. of I. College of Medicine.

do what we told him to do. Recent studies have shown how poorly most patients follow our advice.

Is it enough simply to tell the patient our recommendation, and, if his compliance be imperfect, relieve ourselves of responsibility for the outcome? I think not. I think our moral responsibility means we must try to achieve good results by more powerful force of character (some would say charisma, others salesmanship), and by more effective patient education.

Can methods and hardware of modern education help you do that job with *your* patients in *your* office? I think so. Recently I published an article on this subject (with a dermatological slant, I admit) suggesting some specific techniques. If you're interested, I'll gladly send you a copy.

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Oct. 7-11	Intensive Course in Pediatric Nutritian for Nutritionists and Dieticians	Nov. 8	Postgraduate Conference on Surgery
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Oct. 11-12	The Evaluation and Management of Pain (Physical Therapy)	Nav. 9	Cancer Teaching Day
Oct. 24-26	Antibiotics and Infection—Caurse in Infectious Disease	Nav. 18-22	Intensive Course in Pediatric Nutrition far Nutritianists and Dietitians
Oct. 25-26	Central States Society of Industrial Medicine and Surgery	Nov. 20-21	Medical and Nursing Management of the Acute Alcohalic

## IOWA'S IMMUNIZATION GOAL-TOTAL ERADICATION

CTOBER IS IMMUNIZATION ACTION MONTH.
Immunization against what?

The immunizable communicable diseases of diphtheria, pertussis, tetanus, polio and smallpox, for all practical purposes, have been eliminated in Iowa. Now, the total eradication of rubella (German Measles) and rubeola in Iowa appears a definite possibility.

Totally eliminate these diseases?

Why Iowa?

Iowa has demographic and other features which make the goal realistic—not the least of which is a relatively well-educated, affluent and concerned citizenry.

Who's involved?

The combined efforts of the Iowa Medical Society and the Iowa State Department of Health are imperative if any concerted public and professional program is to be undertaken. With direction from these two organizations and support from other agencies, it is quite possible Iowa may become the "First State to Eradicate."

What's needed for eradication?

Important elements in a broad eradication effort include: (1) a small enough susceptible population to suggest limited opportunity for disease spread; (2) an adequate surveillance system; (3) a set of procedures to assure and/or confirm diagnosis; (4) adequate personnel and facilities to provide epidemiology to surround any confirmed case; and (5) a concerted professional and public education program to stimulate early and adequate immunization with total eradication the end goal.

The preceding italicized passages are from a statement endorsed in May by the Iowa Medical Society House of Delegates.

So this brings us to October. And Immunization Action Month. What is Immunization Action Month? It is No. 5 above.

What is the immunization status in Iowa?

The first statewide school-enterer immunization survey was taken of kindergarten and first grade students in 1973-74. The estimated first year enrollment was 46,232, with responses tabulated

from 30,189 (65.3%). The combination DPT (diphtheria, pertussis, tetanus) vaccine was reported by parent respondents as having been administered to 94.4% of the children (either all or part of the full series). Polio protection was reported as having been provided either totally or partially to 92.3% of the children. Receipt of rubeola (measles) vaccine was noted among 76% of the children. And rubella (German measles) vaccination was reported by 70.9% of the respondents.

The 1974 national observance of Immunization Action Month finds Iowa in a favorable position. But obviously we must not be content to stand by casually when federal reports indicate the percentage of children immunized against childhood diseases has been declining.

The Iowa Medical Society Committee on Maternal and Child Health has recently circulated immunization information to each of its affiliated 92 county medical societies. A county society plan for communicable disease eradication was submitted for consideration. This plan (1) suggested the appointment of an immunization chairman to be the liaison medical contact with public health or school nurses, departments of health, etc.; (2) recommended practicing physicians have their staff audit the immunization records of preschool patients and report to the parents any immunization deficiencies; and (3) urged county medical societies and individual physicians to conduct immunization education programs.

In a recent letter to county society presidents, IMS President R. L. Wicks, M.D., Boone, said, "Obviously, there is little likelihood the goal of eradication will be achieved unless broad and active support is provided by the Iowa Medical Society, its constituent county medical societies and its individual practicing members."

Dr. Wicks added, "We believe the circumstances are right for Iowa to become the 'First State to Eradicate' the immunizable diseases of diphtheria, pertussis, tetanus, polio, rubeola and rubella."

Right on!

## IN THE PUBLIC INTEREST



# The Question Box

by DAVID NEUGENT

Dave Neugent has been president of Blue Cross of Iowa for approximately two years. He responds here to questions about Iowa's health care scene.

You have special expertise in health care economics. What brief comment do you have on Iowa's status in this area?

Although health care costs have risen in Iowa since the end of wage and price controls, it was a natural result. Providers had been absorbing rising costs for 27 consecutive months and needed some relief. They showed remarkable restraint in adjusting rates and fees which, I think, indicates a strong social conscience. Data from the Blue Cross Association and the Iowa Hospital Association show that Iowa's health care costs have traditionally been less than in contiguous states with the exception of South Dakota. The number of admissions per thousand and the length of stay have also been below average in Iowa. This situation still obtains.

Do the legislative events (both culminated and anticipated, e.g., PSRO, NHI, etc.) fill you with apprehension, elation or what?

Optimism and concern best express my attitude toward PSRO, NHI, and health planning legislation. My optimism stems from the fact they have great potential for making quality health care available and affordable.

My concern is rooted in worry over whether these programs will allow the free practice of medicine. Peer review through PSRO mechanisms must be physicians governing physicians at the local level or any cost-effectiveness it brings isn't worth it. NHI can make health care every American's right which is a great objective, but it must not restrict the physician's choices. Health planning can make health care more efficient but it shouldn't dictate how, when, and where a physician should treat a patient.

All programs like these should be locally administered. Just as Blue Cross and Blue Shield work best because they are close to the people they serve, so should government programs be local in their thrust.

From your knowledge of health care availability and quality about the country, how does Iowa stack up?

Iowa has the same problems most of the country has. Distribution is at the core. A recent study showed areas with an abundance of physicians while others were distressingly short. This is a difficult problem, but we in the health care system must solve it. If we cannot bring physicians to the people who need them, then we must find new ways to bring the people to the physicians. The problem needs imagination and hard work under the guidance of the medical profession.

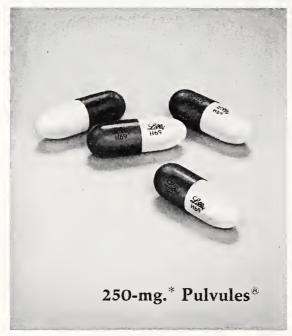
As a boy in Green Bay, Wisconsin, my family was only comfortable with a physician who had been trained in Germany or England. Medical schools there were thought to be superior to those in the United States. That may or may not have been true then, but it most certainly isn't true today. The United States is the center of medical accomplishment in the world. The quality of our physicians cannot be challenged nor can our medical schools and our medical centers in Iowa. I have been told repeatedly by deans of out-of-state schools that Iowa has identifiably great doctors; indeed many have national reputations as leaders and scholars and teachers in various health specialties.

Leadership in health care delivery will obviously be crucial in the next few years. Will the leadership opportunity be locally available (to those of us in the states) and do we in Iowa appear up to the challenge?

(Please turn to page 437)

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# Multiple Myeloma in Iowa

MANUEL N. CALLIS, M.D., and RAYMOND F. SHEETS, M.D. lowa City

Herein are presented 318 cases of multiple myeloma, most of the cases filed in the Tumor Registry of the University of Iowa Hospitals since 1940. Of these cases, survival data were available in 277 (87% of the total), excluding 24 cases still alive as of April, 1973. Forty-seven autopsies were performed on 14% of the total number.

### DIAGNOSIS

Every case was identified and the diagnosis reviewed. The diagnosis was confirmed in all but 3 cases which were excluded with the primary diagnosis of macroglobulinemia, amyloidosis and rheumatoid arthritis. The diagnosis was accepted if at least 2 of the 3 major criteria were fulfilled:

a) osteolytic bony lesions and collapsed vertebra, b) protein abnormalities in serum or urine, c) bone marrow plasmocytosis or typical myeloma cells. In a few earlier cases the diagnosis was made pathologically on tissue sections, although solitary plasmocytomas were excluded from this

The authors are associated with the Department of Internal Medicine (Division of Hematology-Oncology) at The University of Iowa College of Medicine. Dr. Callis has fellowship status and Dr. Sheets is a professor.

study. In 2 cases the diagnosis was made only at autopsy.

The presence of Bence Jones protein was determined originally by the heat test and later by the sulfosalicylic acid test (1960) and immuno-electrophoresis (1965). The latter has been performed routinely on serum and urine of all mye-

Survival statistics for 277 cases of multiple myeloma are presented. Different treatment approaches are compared. Early diagnosis affords optimum management potential.

loma cases since 1970. By the application of these procedures, 108 patients, or 34% of the total, demonstrated light chain proteinuria at one point or another of their disease. Of the 28 cases so typed, 16 have proved to be  $\kappa$  chain and 12  $\lambda$  chain proteinuria, or 57% and 43% incidence, respectively.

Since 1965, the M-spike was further characterized by immunoelectrophoresis in 64 cases which yielded 45 cases of IgG and 19 cases of IgA, or 70% and 30%, respectively.

Light chain disease was diagnosed in about ½ of the patients with Bence Jones proteinuria. The diagnosis was made directly, demonstrating free light chains in both serum and urine in 8 cases and retrospectively in 24 on the basis of Bence Jones proteinuria, normal or low total protein, and normal protein electrophoresis introduced

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routinely in 1960, including a picture of hypogammaglobulinemia combined with some elevation of the a2 fraction and without the characteristic monoclonal spike. The overall incidence of light chain disease would be around 10% of the Tumor Registry.

Ten additional cases were identified as myeloma with hypoproteinemia on the basis of a total serum protein of less than 6 gm% and absent Bence Jones by the less sensitive method of heat testing.

The overall incidence as we now classify multiple myeloma compared with other known studies is pictured in Table 1.

TABLE I

		Jones	(212)	Jones	Osserman (351) %	Bence Jones %
IgG myeloma	60	(49)	53	(62)	52	(39)
lgA myeloma	26	(42)	25	(70)	22	(38)
Light chain disease .	10		19		25	
Myeloma & hypopro-						
teinemia	3					
Myeloma without						
protein changes	1					
		,	, Kapp % Laml	,		, -

These results are comparable, indicating our sample is well representative. Our lower incidence of light chain disease simply relates to the inclusion of earlier cases wherein techniques for determination of light chains were not very sensitive. Our results also indicate a prevalence of  $\kappa$  chains as compared to  $\lambda$  as in the biological system (proportion of 2:1) indicating the random selection of the myeloma clones.

### SURVIVAL

Survival data were calculated to the nearest two weeks from the date of admission at which time the diagnosis was made to the date of demise as recorded in the Tumor Registry.

Firstly, comparison of survival between patients on chemotherapy and patients who at most received palliative radiation is shown in Figure 1. There were 107 cases receiving symptomatic treatment and 174 receiving chemotherapy, primarily Urethane, Cytoxan<sup>®</sup> and Alkeran<sup>®</sup>, including 15 cases receiving a variety of drugs (eponate, nitrogen mustard, stilbamidine, 6-mercaptopurine, hexamethylmelamine). The value of chemo-

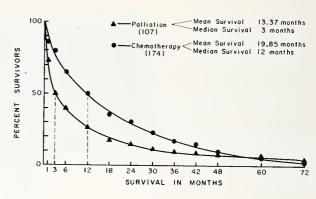
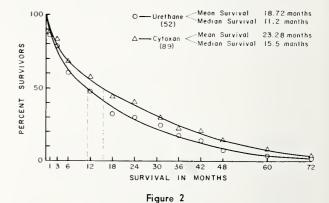


Figure I

therapy was assessed by the prolongation of median survival from 3 to 12 months and the mean survival from 13.37 to 19.85 months.\*

The specific value of chemotherapy was assessed by comparing 52 cases treated with Urethane (introduced 1951) and 89 treated with continuous Cytoxan therapy (introduced 1961). Results are presented in Figure 2 and show a prolongation of the median survival from 11.2 months to 15.5 months, favoring the Cytoxan treated group. The mean survival was also prolonged from 18.72 months to 23.28 months. We have 4 patients alive on Cytoxan with 50 months average



followup. There were not enough survival data on Alkeran (introduced 1968) for analysis. Only 18 patients have died on this drug with a median survival of 12 months and mean survival of 16.66 months. However, there are more than 20 patients alive on the drug with 22.8 months average followup.

Regardless of the therapy used, we have made 2 other correlations with survival.

<sup>\*</sup> Median survival p < 0.005. Large sample one-tailed Kolmogorov-Smirnov test.

We could not demonstrate a significantly shortened survival in patients with Bence Jones proteinuria. Ninety-two cases with Bence Jones proteinuria had a median survival of 9 months and mean survival of 15.96 months compared with 117 cases with a negative test who had a median survival of 10.5 months and mean survival of 19.09 months. The latter group approached the mean survival (19.85 months) for treated patients as a whole.

In Figure 3 we plotted mean survival in relationship to the total protein at the time of diagnosis, these being grouped at intervals of 2 gm of protein. The lowest survival was found in the hypoproteinemic group (4-6 gm) and the highest in the mildly hyperproteinemic (8-10 gm) to decline with increasing levels of serum proteins. The analysis of variance statistics between groups was significant (p < 0.5). The quadratic effect on median survival with protein values was also significant at the level of p < 0.025 and the best function derived could be expressed as follows:

These data would indicate that myeloma tumors with hypoproteinemia, probably due to abortive heavy chain synthesis, are more malignant since they have a shorter survival and by the same token, more frequently immature myeloma cells in the bone marrow.<sup>4</sup> On the other hand, patients presenting with very high levels of total protein have a sizeable tumor load, and also a diminished survival probably due to late diagnosis.<sup>10</sup>

### COMPLICATIONS

One of the most dreadful complications of multiple myeloma is spinal cord compression, quite often the presenting symptom. Undoubtedly, progress in diagnosis has been made and earlier diagnosis and therapy has diminished considerably its incidence. Before 1960 there were 14 patients with this complication out of 140 patients in the Registry, or 10% incidence. This has declined considerably since with an incidence of 3.8% in the period of 1960-1970 and continues to decline.

The incidence of hypercalcemia (serum calcium greater than 11 mg%) and severe uremia (BUN greater than 100 mg% and creatinine greater than 5 mg%) in the autopsy group was 42% and 55.5%, respectively. The subject of myeloma kidney will be dealt with in a separate study.

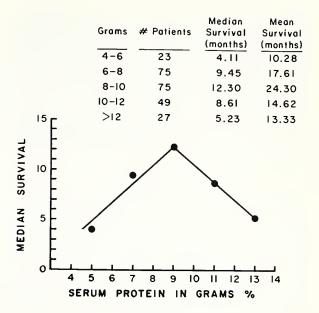


Figure 3

As recently reported, the incidence of amyloidosis is less than anticipated. We only found it in 4.4% of the autopsy cases and in 1.7% of the total cases, including biopsies of suspected cases. It followed primarily the distribution of the idiopathic variety except for 1 autopsy case in which it was confined to the spleen.

The association of solid malignancies is well known and we found it in 9 instances:

Carcinoma of the lungs	ì
Carcinoma of the colon	
Papillary adenocarcinoma of the thyroid	
Astrocytoma	
Metastatic carcinoma of the liver	
Carcinoma of the prostate	
Adenoacanthoma of the uterus	

However, only in 3 cases (thyroid, colon, liver) did the solid tumor present as a second malignancy. Remarkable is the case of S.C. who had 2 malignancies removed: astrocytoma in 1954, squamous cell carcinoma of the lung (Pancoast) in 1959, to die of multiple myeloma in 1962.

We have not observed transformation into acute leukemia but we have seen one case of sideroblastic anemia following chemotherapy and in clinical remission, a condition that has been reported by Khaleeli<sup>17</sup> as a preleukemic condition.

Following the series reported by Pruzauski<sup>11</sup> we found only 3 cases of plasma cell leukemia. Circulating plasma cells are frequent in myeloma, particularly if sought for in the buffy coat. In 2 cases, the degree of plasmacytosis was mild (1610 and 2640/cu mm) and was accompanied by a

shift to the left in the white count, suggesting a myelophthisic process and the third one was well in the leukemic range (123.700 plasma cells/cumm). As reported, these patients frequently had hypercalcemia and azotemia and therefore, a poorer prognosis.

Finally, an interesting observation in the last 3 years has been 2 cases of hypothyroidism associated with IgA myeloma whose relationship is as yet conjectural.

### AUTOPSY

The direct cause of death in 47 patients was attributed after postmortem examination to infection (66%), bleeding (6.3%), uremia and complications of dialysis (6.3%), sudden death (12.8%) and unrelated (8.5%).

The most common infectious complications were respiratory (19 cases), including lobar pneumonias, bronchopneumonias, aspiration and hypostatic pneumonias. There were 8 cases of septicemia with the following organisms isolated: staphylococcus aureus 2, proteus mirabilis 2, klebsiella aerobacter 1, streptococcus faecalis 1, pseudomonas aeruginosa 1, and escherichia coli 1.

Roughly half of the patients in both groups had some degree of myelosuppression, either due to chemotherapy, myelophthisis, or both.

Central nervous system infections occurred in 4 patients: 2 had Diplococcus pneumonia meningitis, 1 had Cryptococcus meningitis and 1 had a necrotizing ventriculitis most likely due to Fusciformis anaerobis.

Isolated bleeding complications occurred in 3 patients: 2 had subdural hematomas both with platelet counts below 20,000 and 1 had a ruptured spleen, platelet count of 38,000.

Since leukopenia and thrombocytopenia are associated with these fatal complications, the role of chemotherapy was investigated. Of these, 16/28 had less than 100,000 platelets/cu mm within a week before death and 13 had chemotherapy within the previous month. Another 13/43 had granulocytopenia of less than 3,000 neutrophils/cu mm within a week before death and 11 had chemotherapy during the last month. Altogether, 7 patients had neutropenia and thrombocytopenia the week before demise and received chemotherapy the previous month, thus making up 15% of death's toll in which chemotherapy might have contributed.

Other pertinent autopsy findings were the degree of spread or infiltration of the tumor. Most common was the production of tumors arising from bones, extradural masses (3), epidural (2) and soft tissues adjacent to bone. Infiltration of visceral organs was uncommon except possibly the GI tract (esophagus, stomach, intestines, pancreas). Endocrine organs were rarely involved, thyroid and adrenal on one occasion each.

Special attention was paid to organs of the reticuloendothelial system, liver, spleen and lymph nodes, all of which were involved roughly in ½ of the cases, and over half of the time the involvement of the three was simultaneous. In 5 cases evidence of extramedullary hematopoiesis was found in these organs, particularly in the lymph nodes.

### DISCUSSION

Obviously, the most difficult assessment is the life-span of the untreated myeloma, bearing in mind that earlier diagnosis in itself prolongs survival. Published figures range from 3.5 to 9.1.<sup>13</sup> Osgood reported 7.1 months (192 patients in 1960),<sup>1</sup> the Midwest Cooperative group 8.7 months (181 patients in 1964),<sup>2</sup> the NCI 8.2 months up to 1964, making the special point that survival correlated with age and therefore, we should appraise the problem in terms of relative survival.<sup>15</sup>

The value of Urethane has been disputed by several authors. Although it was known to induce remissions, survival studies were not significant. Our figure is close to the 13.5 months reported by Korst, and in our series Urethane proved to be valuable and the first step toward effective therapy.

With continuous administration of Cytoxan, both Korst<sup>3</sup> and the Medical Research Council<sup>14</sup> reached similar figures, 24 months median survival, which at that time was similar to survival rates with Alkeran. However, in most recent reports, Alkeran is stretching survival to 24 months (Bergsagel 0.7-1.3 mg/kg every 6 weeks),<sup>5</sup> 28 months (McArthur 4 mg daily), 12 34 months (Alexanian 0.7-1.3 mg/kg every 6 weeks) 6 although the same author could not repeat his results using 0.025 mg/kg/day, and intermittent Alkeran  $0.25 \text{ mg/kg} \times 4 \text{ days}$ , with and without Prednisone 2 mg/kg/day × 4 days, obtaining median survivals from institution of therapy of 18 months for either schedule of Alkeran alone and 24 months for the combination of Alkeran and Prednisone.

Most encouraging recent reports come from Osserman,<sup>16</sup> claiming 51.5 months survival from diagnosis and 42 months from initiation of therapy

with Alkeran (6-8 mg  $\times$  10 days, followed by a rest period of 4 weeks, then 2 mg/day WBC adjusted maintenance) in 30 patients who received the drug for more than 2 months.

We made no attempt to define response rates but most authors emphasized that responding patients survive much longer than non-responders,12 the latter sometimes approaching the rates of nontreated patients. The most widely accepted response criteria is the one set up by Carbone,7 which includes at least one of the following: a) 50% decrease in serum M-spike or urinary Bence Jones excretion, b) 50% decrease in palpable tumors, and c) bone healing.

According to most series, 18 60-70% patients will respond to adequate trials of chemotherapy. Hobbs, 10 however, separated into fast and slow responders, according to the rate of reduction of the abnormal protein at 10 weeks, and observed the fast responders survived almost like the nonresponders, since as a group they tended to relapse quickly.

Fortunately, there is no cross resistance between Cytoxan and Alkeran and there, if one drug fails, the other drug should be tried. Ogawa<sup>18</sup> has shown that quantitative cell cultures can predict the in vivo chemotherapeutic response in mouse myeloma. Presently, members of the Eastern Cooperative Oncology Group are evaluating the efficacy of a combination of BCNU, Cytoxan and Prednisone, and also initiating studies with Adriamycin for non-responders and Bleomycin for terminal patients with myelosuppression.

Finally we want to emphasize that the initial level of total protein or the M-spike has definitely a prognostic value. Thus, longest survival is expected in patients with initial total protein levels between 8-10 gm%. We hope with the use of an automatized analyzer, more patients can be screened and diagnoses reached earlier, therefore improving the chances of managing these patients.

#### **SUMMARY**

We have reported here median survivals from time of diagnosis for 277 cases of multiple myeloma. We found a median survival of 3 months in the symptomatically treated group (107), 11.2 months in the Urethane group (52), 15.2 months in the Cytoxan group given continuously (89) and at least 17 months in the Alkeran group, including intermittent and continuous administration (38).

Patients with mild hyperproteinemia have increased survival over those patients who have abnormally low or high concentrations of serum protein. The combination of Alkeran and Predisone appears to be the most efficacious treatment in our series of patients.

### **ACKNOWLEDGMENTS**

We gratefully acknowledge the assistance of Dr. Robert Woolson, Department of Preventive Medicine, Lauro Lanoue, Medical Records Department and Sandra Kouba, Internal Medicine.

### REFERENCES

The references noted in this article may be obtained from either the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Intensive, dynamic psychotherapy for adults ▲ Milwaukee Psychiatric Hospital and adolescents, individually planned activity therapy.

Geriatric program of superior care . . . custodial services for persons with chronic emotional illness. ▲ Milwaukee Sanitarium

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# Acute Bacterial Endocarditis With Septic Emboli

CHING L. CHIU, M.D., and JAMES D. ROELOFS, M.D. lowa City

A BLACK FEMALE, age 27, was admitted to her local hospital after an approximate one week history of malaise, fever and increased sputum production. Significant in the history was the patient's intravenous use of heroin the last 3-4 years. The patient had discontinued the drug and gone through withdrawal when she first became ill. She was admitted to her local hospital where six of six blood cultures were positive for a species of aerobacter. She was treated with ampicillin and gentamicin, but after a week of therapy was still spiking fever. In addition, her hemoglobin had fallen from 8.8 to 6.8 gm. After two weeks of hospitalization with blood cultures still positive, she was transferred to University Hospital.

### PHYSICAL EXAMINATION & LABORATORY FINDINGS

Significant positive findings on initial examination: blood pressure 90/50, pulse 130/min., and temperature 37.7 C. The patient had a grade II-III/VI holosystolic murmur heard over the entire anterior precordium which increased with inspiration. Liver size was percussed to be 11-13 cm superior-inferior dimension with positive hepatojugular reflux. The spleen was not palapable. There were rales in both lungs with a questionable audible pleural friction rub. The neurological exam was within normal limits. At that point repeat blood cultures showed two species of serratia.

### RADIOLOGIC FINDINGS

The admission chest radiograph showed multi-

The authors are associated with the department of radiology at the University of Iowa College of Medicine.

The case of endocarditis described here is unique in that it represents a rare instance when the cause is Serratia marcescens. Noted is the frequency of septic pulmonary emboli in patients with a history of intravenous drug abuse.

ple thin walled cavitary lesions and pneumonic infiltrates scattered through both lung fields, but the cardiac size was normal (Figure 1). The findings were consistent with multiple pulmonary abscesses. Technetium-99m sulfur-colloid liver and spleen scan demonstrated decreased activity in the slightly enlarged liver. The spleen was enlarged and its activity was quite intense. There was activity in the lumbar vertebrae (Figure 2). This is suggestive of diffuse hepatocellular disease. A cardiac catherization and cine angiocardiogram revealed filling defects attached to the tricuspid valve, presumed to be bacterial vegetations

### HOSPITAL COURSE

Following culture results, the patient was treated with gentamicin and chloramphenicol. One day later carbenicillin was added but the patient continued to spike fever. After three days on this therapy the patient had an acute episode of tachypnea (60/min.) with a drop in blood gases to  $P_AO_2$  47 mm Hg, pCO<sub>2</sub> 18, and pH 7.48 which responded to O<sub>2</sub>. This episode was attributed to pulmonary embolization from either a septic or thromboembolic source.

In view of the episode of further pulmonary embolization and a history of continued fever and positive blood cultures, it was concluded the patient needed to have the focus of her infection removed. At the time of operation, she was found to have large vegetations on the tricuspid valve and on the ventricular septum. The vegetations and the valve were removed. Post-operatively she

(Please turn to page 436)

### Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

### Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce — information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

### Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

### The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

### The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

### Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005



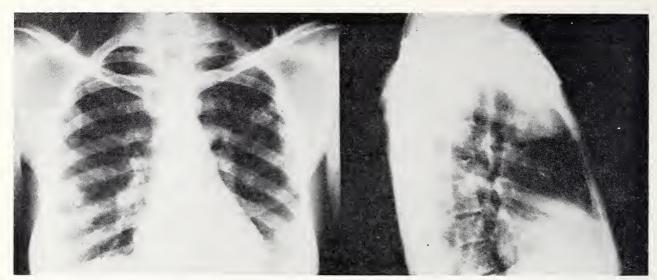


Figure 1. Admission chest film: This exam shows multiple thin-walled cavitary lesions and pneumonic infiltrates scattered throughout both lung fields. The cardiac size is normal.

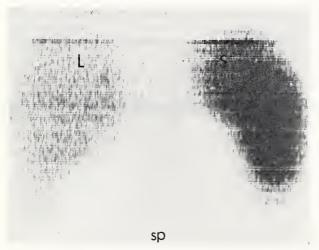


Figure 2. Liver, spleen scan: The liver is slightly enlarged with decreased activity. The spleen is enlarged and its activity is quite intense. There is also activity in the lumbar vertebrae. This suggests diffuse hepatocellular disease.

required continuous vasopressor therapy. In the evening following her operation she became unresponsive to vasopressors and expired.

### DISCUSSION

Jaffe and Koschmann<sup>1</sup> reviewed 17 cases of septic pulmonary emboli and found 13 had a history of drug abuse. The emboli were thought to arise from right-sided endocarditis in 11 patients and sites of septic thrombophlebitis in 4. Two patients had both. Eight of the 17 had coagulase positive staph aureus isolated from the blood. Staphylococci and streptococci constitute the majority of organisms isolated.<sup>2</sup> The clinical presence of endocarditis with emboli may be quite variable

and puzzling. Cardiac problems arise with altered function or destruction of the cardiac valves. Emboli may occlude the coronary arteries causing myocardial infarction. Cerebrovascular emboli may present with meningitis or hemiplegia. Pulmonary emboli may present as pulmonary artery occlusion or as multiple cavitary infections.4 In patients without a history of intravenous drug abuse, other sources of septic thrombophlebitis or right-sided bacterial endocarditis should include pharyngeal infection,<sup>5</sup> lateral sinus thrombosis, infected indwelling catheters, arteriovenous shunts, septic thrombophlebitis complicating pelvic infection, congenitally damaged valves, sites of congenital defects, rheumatic or atheromatous damage, prosthetic valves,7 previous G.U. tract instrumentation or abortion.8

### SUMMARY

This is a review of the literature and a report of one case of endocarditis caused by Serratia marcescens with multiple septic emboli. As discussed previously, the patient with endocarditis may present with a variable array of clinical manifestations. The presence of multiple round pulmonary lesions in a patient with a history of intravenous drug abuse should alert one to the diagnosis of septic pulmonary emboli. Endocarditis is the most common etiology of septic emboli. However, the clinical and roentgenographic ap-

pearance of septic emboli may be mimicked by a wide variety of inflammatory, vascular, neoplastic and collagen diseases.<sup>18</sup> The importance of early diagnosis and treatment of this problem must be emphasized. The case discussed is unique in that Serratia is a rare cause of endocarditis.

#### REFERENCES

The references noted in this article are available on request from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

### QUESTION BOX

(Continued from page 427)

I believe that leadership of the health care system must come from the physicians. Government may point the way to new patterns of care,

but it is the doctors who should take us there. Unfortunately, the doctor is already the busiest man in town. If he is to take his rightful place as leader, then we, the providers, payors, and consumers must become the doers under his guidance. He cannot do it alone; we cannot do it without him. Together we can bring Iowa quality health care that is available and affordable.





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### The Battered Child

HAROLD A. YOUNG, J.D. Des Moines

The medical practitioner's treatment of the abused child goes beyond the body mending process. It involves measures to curb likelihood of recurrence. The attorney author urges physician reporting of suspected cases.

THE BATTERED CHILD SYNDROME has become a recognized medical diagnosis of a condition wherein children are injured other than by accidental means. The medical profession is confronted on an irregular basis with the "accidentally" injured child where history of injury and results of examination do not coincide.

How does—or should—the practitioner respond to the abused child? Both the Iowa law and serious ethical considerations dictate a bifurcated approach. First, obviously, the injuries should and must be treated to restore the child to health. But the physician's treatment responsibility does not cease at that point. Child abuse is generally not an isolated episode, but a continuing condition; it is however a preventable condition. It is therefore the additional responsibility of the physician in cases of actual or suspected child abuse to initiate the prevention phase of treatment. Just as the medical practitioner attempts the prevention of substandard family conditions, which result in disease, he should also exercise his responsibility to prevent the conditions resulting in battered children.

The 1973 Code of Iowa, Chapter 235A.3 requires that:

"Every health practitioner who examines, attends or treats a child and who believes or has reason to believe that the child has had physical injury inflicted on him as a result of abuse or willful neglect, shall make a report as provided . . . however, if the health practitioner examines, attends, or treats the child as a member of the staff of a hospital or similar institution, he shall immediately notify and give complete information to the person in charge of the institution or his designated representative, who shall make a report as provided . . ."

The reporting provisions of this State law require that both an oral and written report be made as soon as is reasonably possible. The oral report is to be made by telephone to the county department of social welfare. When the reporting person believes immediate protection of the child is advisable he is to make an oral report to "an appropriate law enforcement agency," generally the county juvenile court.

Normally, the physician's role is only that of the initiator. The whole purpose of the reporting process is to focus the community's treatment and preventive resources upon the conditions causing the abuse. The county departments of social welfare, now referred to as departments of social service, have trained workers who are able to deal effectively and sympathetically with the problems of child abuse. Local juvenile court departments are also dealing with these problems with success, and growing awareness that child abuse is a social problem rather than one of a criminal nature had led many, if not most, prosecutors to rely on these community services rather than the over-reactive filing of criminal charges against the parents. But these services cannot be brought to the problem if the agencies are not made aware of the abuse or suspected abuse condition.

How has the medical practitioner responded to the abused child? On the basis of available, although sketchy, information it would appear that all too frequently the physician may be ignoring his prevention responsibility. During a recent child abuse seminar at University Hospitals in Iowa City, physicians, social workers, lawyers and state legislators agreed the number of re-

The author serves in Des Moines as an assistant county attorney for Polk County.

ported cases of child abuse is merely "the tip of the iceberg." It appears a majority of cases go unreported—a critical generality which represents a gloomy picture. Yet the figures produced at this seminar posed even more serious questions for consideration. Of the 252 reported cases of child abuse in Iowa in 1972, 11 were reported by doctors and 24 by hospitals. (Most reports appear to come from relatives, neighbors, police.)

Why so few? Even the question is realized as being assumptive—and without supportive facts. But can it be reasonably assumed that only 35 cases of injured children in 1972 raised the suspicions of the medical profession in the entire State? Of all the theories tendered for the (alleged) failure of doctors and hospitals to report child abuse, all but one can be rebutted by reference to the profession's legal and ethical responsibilities.

The single exception is the issue of liability raised by reporting suspected child-abusing parents. The answer to this question (fear) is simple.

Under Iowa law, by specific statutory enactment, there is no liability, civil or criminal, for (or against) any person making a child-abuse report as long as they act in good faith. No doctor, nor hospital, nor any person whatsoever can be held liable for any nature of damage-whether for slander or otherwise—unless they were shown to have acted maliciously. Quite to the contrary, there has been a growing number of cases recently where doctors and hospitals were held liable for their failure to report when required to do so. and there was subsequent injury to the child. In other words, the practitioner who fails to report a suspected child abuse case because of a concern for legal liability, may well be creating liability rather than avoiding it.

In addition to treatment of the abused child, the medical profession *must* report its findings so that further injury or death can be prevented. Perhaps in this dual role of responsibility, as in no other area, is the remonstration so poignant: Doctor, your patient's life is in your hands.

### IOWA MEDICAL MISCELLANY

(Continued from page 421)

PLANNING CONTINUES . . . The Iowa Foundation for Medical Care is continuing planning activities relative to PSRO. A planning grant has been received from HEW. Next step will be an application for conditional PSRO status.

**NEW APPROACH...** Customary fee profiles are being derived by Blue Shield from statewide data as of mid-September. The determinations are made by specialty. New statewide approach still excludes University Hospitals. Previously, seven separate profile areas were used.

AMA/CPT... Distribution of the AMA Current Procedural Terminology to Iowa physicians is virtually completed. IMS members are urged to use the CPT in coding claims. Blue Shield is now able to convert CPT coding to its system. By January 1 BS expects to be programmed for direct use of CPT coding and will abandon the conversion process. Blue Shield's fall series of

doctors' secretaries meetings will be on this subject.

ENROLLMENT CONTINUES . . . New IMS group health care coverage initiated this year through Blue Cross/Blue Shield remains in an open enrollment status through December. Reported participation: 212 groups, 602 contracts, approximately 1,500 subscribers. The broad benefits include major medical coverage up to \$250,000. Plan is available to IMS members, their families and employees. Committee on Group Insurance urges consideration of the plan.

BOARD OF HEALTH . . . Paul Leehey, M.D., Independence, and Paul Seebohm, M.D., Iowa City, have been reappointed to three-year terms on the State Board of Health. E. E. Gamet, M.D., Lamoni, third medical doctor on the Board, serves as president.

SURVEY PROJECT . . . IMS Committee on Maternal and Child Health has circulated survey to county medical societies regarding immunization activities. County societies are requested to designate an immunization chairman to serve in a liaison capacity with the M&CH Committee and the State Department of Health.

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To a busy professional person there just doesn't seem to be enough hours in a day. An you'd still like to have some time for your family; some time to relax. So, if you try to manage your investments yourself, it's got to be either at the expense of your alread limited professional time . . . or of your leisure.

### CAN PART-TIME INVESTMENT MANAGEMENT SUCCEED?

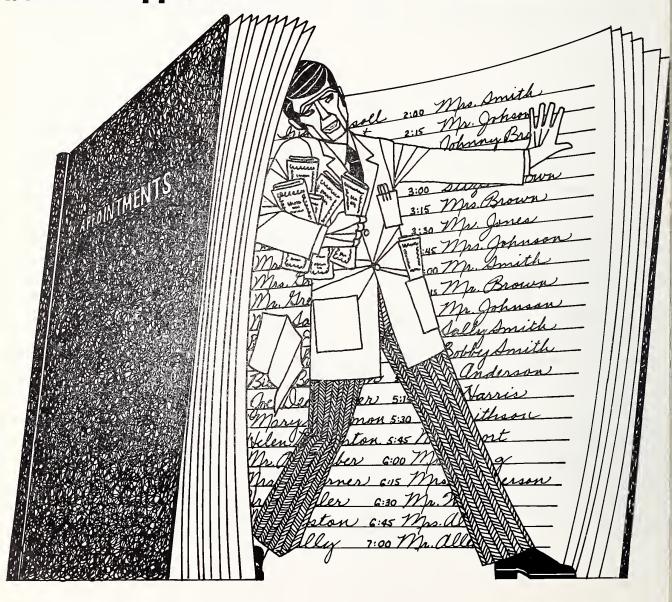
The odds are against it. Make no mistake, managing investments is a full time job for experts. You certainly wouldn't think much of a layman try ing to practice your profession, would you? But some people try invest ment management on an amateur, part-time basis, often with sad results

### HOW TO GET HELP

There is a way for a busy professional person to get the kind o investment help he needs. That's what lowa Bank Trust Depart ments offer with a Managing Agency or Living Trust. You'l sleep better knowing your investments are getting the attention they deserve. And you'll have a lot more time for other things!

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IOWA TRUST ASSOCIATION of bank trust departments





M. E. ALBERTS, M.D., Scientific Editor

# IMMUNIZATION ACTION MONTH —1974

It is beyond my comprehension why some parents do not provide the benefits of immunization for their children. Protection against poliomyelitis, tetanus, and other diseases is so easily accomplished, yet many are without that protection. There is an alarming decline in immunization levels among 1-4 year old children against poliomyelitis, diphtheria, pertussis, tetanus, measles, rubella, and mumps. In 1963, 84.1% of 1-4-year-old children were immunized against poliomyelitis; in 1973, only 60.4%. Obviously, education is urgently needed to convince people of the value of such measures, simply how to obtain the immunizations their children need.

October has been designated "Immunization Action Month." Many private and public health agencies are cooperating to make this a successful campaign. In Iowa, our long-range goal is to be the "First State to Eradicate."

Our efforts in the past have been successful in part, but they have not been enough. Over 500,000 doses of rubella vaccine were administered to pre-pubertal children in 1970; over 100,000 doses of measles and measles/rubella vaccine have been administered in public programs in the past two years. There has been an increased use of vaccine in private physicians' offices. But this has not been enough because deficiencies do exist. Often we do not follow through with our patients to provide the childhood immunizations. Perhaps we do not insist adequately. Preventive medicine entails education; we must almost demand that immunizations be part of the contract. If the phy-

sician is to be called regarding various illnesses he has the right to insist that his patients fulfill the obligation to help themselves. Some may call this coercion, but it is still a part of the obligation to practice preventive medicine just as much as it is to order isolation of a patient with a contagious disease.

Any physician who has witnessed a previously robust child die or become crippled due to poliomyelitis, or a previously intelligent youngster rendered mentally incompetent by measles encephalitis could not conscientiously ignore the value of vaccination. Do your best this month, and every month, doctor, to emphasize the value of immunization. Review the records of each patient during any of their office visits to determine if protection is complete. If a parent declines to have the child immunized note this on the chart in full view of the parent; let him know you are making the notation: "Parent declines immunizations." If the family needs are great and immunization imposes a financial burden, information regarding public clinics should be provided. There will be more information forthcoming regarding immunization clinics.

It is not enough to say, "Get your shots"; a vivid picture must be painted of the consequences of neglect. When Salk vaccine became available during the poliomyelitis epidemic of the 1950's people suddenly and frantically sought immunization. Then, when the epidemics disappeared so did the fear and the decline in immunization slowly began. Let us emphasize that we do not subscribe to the old adage that "out of sight—out of mind." Paint true pictures of the need for immunization. Educate the people. Be sure they truly "get the point"—the end of the needle attached to a syringe of vaccine.—M.E.A.

### SELF-EVALUATION PROGRAMS

"Fortunate, indeed, is the man who takes exactly the right measure of himself, and holds a just balance between what he can acquire and what he can use, be it great or be it small!"—Peter Mere Latham (1789-1875) from Lectures on Clinical Medicine, Lecture I.

To know one's self is valuable. The medical profession is in a swiftly moving current of advancing knowledge. The physician, however, may become entangled very easily by an undercurrent of complacency and remain in one place. The very unfortunate aspect of this complacency is that the individual physician may not fully realize his predicament. If the medical school graduate of 1950 were practicing what he had learned then, without further advancement, his practice methods would be of the dark ages variety.

We are constantly being urged by our various organizations to be involved with refresher courses, seminars, post-graduate training programs, and learning methods such as monographs and audio-visual programs. Some physicians very actively involve themselves; others let the mainstream go by and entangle their lives in a humdrum practice of medicine.

In recent years various organized segments of our medical profession have provided a means whereby we can learn where we stand in relation

ANTIBIOTICS & INFECTION CONFERENCE IN OCTOBER

The fifth annual Conference on Antibiotics and Infection will be at the University of Iowa Hospitals in Iowa City on October 24, 25 and 26. Guest speakers will include Dr. Maxwell Finland, Harvard University; Dr. Philip Y. Paterson,

DEDICATE U. OF I. LIBRARY

Dedication of the new University of Iowa Health Sciences Library occurred September 27 in Iowa City. The library combines the books forto our colleagues in medical knowledge. Selfevaluation examinations provide this means. The Academy of Pediatrics had its first such evaluation examination in 1970, and another this year. The multiple choice questions are derived from questions used by the American Board of Pediatrics. The most recent self-evaluation and education program of the American Academy of Pediatrics had 1,800 registrants, who received question booklets with 225 questions. The questions were truly searching in their coverage; truly revealing to the examinee of his knowledge of contemporary pediatrics.

Another recent test involving pediatrics was sponsored by the American College of Radiology—an examination of 103 questions on many pediatric subjects. There was 1,823 participants, of whom 155 were non-radiologists.

If there is any criticism of these examinations, it might be the relevancy of the question material. The pediatrics examination did ask each participant to evaluate the relevancy of each question, and I am sure the results were revealing. Many questions are about a once-in-a-lifetime diagnosis, and may be of interest to a professor, but not to the practicing pediatrician. On the whole the questions are good, thought-provoking, and certainly provide an excellent opportunity for self-evaluation. There are, furthermore, tremendous educational benefits.

Try one when the opportunity presents.—M.E.A.

Northwestern University; Dr. Leon D. Sabath, University of Minnesota; Dr. Merle A. Sande, University of Virginia; Dr. Arnold Smith, Harvard University, and Dr. Emanuel Wolinsky, Case-Western Reserve University.

For additional information, contact Ian M. Smith, M.D., Department of Medicine, University of Iowa Hospitals and Clinics, Iowa City, Iowa 52242.

merly housed in the medical, dental, pharmacy and speech pathology libraries, plus the nursing collection and 30,000 stored volumes.

The \$4.2 million structure is directly west of Psychopathic Hospital.

by TENORA MEYER, CMA

### RECORD NUMBER PASS CERTIFICATION EXAM

540 CMA certificates—highest number in history—were earned in June. This record includes 23 who passed the new pediatric examination offered for the first time this year. This program is conducted by the AAMA in collaboration with the American Academy of Pediatrics.

Beginning in 1975, the examination will have a new format, consisting of the basic certification examination and three specialty examinations: administrative, clinical and pediatrics.

The AAMA now has 15,500 medical assistants employed by physicians in their offices. The AAMA certification examination is offered annually at more than 70 centers.

### 34 NEW CMA'S FROM IOWA

Iowa shared third place with the State of Washington in having the largest number achieve CMA designation this year. California was first, Texas was second, and Washington and Iowa tied for third. New Iowa CMA's are:

CLINICAL—Donna J. Appleget, Sigourney—Katherine M. Blair, Des Moines—Linda A. Boardman, Cedar Rapids—Diana S. Buck, Des Moines—Sheryl L. Chambers, Knoxville—Julia A. Cooper, Slater—Gloria S. Farrier, Des Moines—Sally Gesink, Sioux City—Elaine Groenendyk, Knoxville—Debra R. Gullord, Des Moines—Lois M. Horak, Vinton—Doris L. Liggett, Des Moines—Guylette M. Morse, Ankeny—Cheryl J. Steiber, Cedar Rapids—Gloria J. Travis, Cedar Rapids—Aletha G. Vande Griend, Boyden—Mary Lou Wiebel, Cedar Rapids, and Mary J. Zismer, Maquoketa.

ADMINISTRATIVE-CLERICAL—Rhona E. Deutsch, North Liberty—Patricia I. Eggers, Clinton—Rosemary C. Herman, Des Moines—Mary E. Hoye, Des Moines—Barbara J. Lyons, Des Moines—Wendy D. McDanel, Cedar Rapids—Margaret J. Mulvehill, Cedar Rapids—Joan A. Natte, Fort Dodge—Janice M.

O'Connor, Iowa City—Diane R. Pedersen, Newell—Margaret M. Porter, Cedar Rapids—Elizabeth G. Ryan, Iowa City—Alliene J. Schluter, Cedar Rapids, and Kathleen J. Van Cleve, Cedar Rapids.

ADMINISTRATIVE—Charlotte J. Fell, West Des Moines, and Frances J. Rosen, Des Moines.

Study guides are available for the certification examination from the American Association of Medical Assistants, 1 East Wacker Drive, Chicago, Illinois. The examination is offered once a year—the last Friday in June.

### INVENTORY SYSTEM

A practical inventory system is essential for any office. You may still run out of certain supplies because of inadequate quantities available. But you will insure a systematic approach to the ordering of the supplies. Either an inventory card or form may be used. If kept up to date, you will always know how much of each item you have in stock, when orders were sent in and received, and how much is used in a given period of time.

Included in the inventory is every expendable item used in the office, from sutures to letterheads and envelopes. The inventory system will also provide a guide when ordering supplies and will enable you to obtain quantity discounts on many items. By listing catalog numbers of the manufacturers on the cards, you will speed up your next order, as such orders usually receive prompt handling and eliminate the task of looking up your previous order. Inventory forms and cards are available from office supply stores.

When you order supplies, keep a copy of your order. By referring to these orders when your count is made, you will prevent a reorder and overstock of the item.

The inventory cards are especially helpful in case there is a turnover in personnel, and the new medical assistant will know where to obtain supplies by checking the inventory card.

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.



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# **About IOWA Physicians**

Dr. Pedro O. Atienza has joined the Davenport Clinic to practice surgery and general medicine. Dr. Atienza received his medical education at University of St. Thomas College of Medicine and Surgery in Manila, Philippines, and recently completed a four-year residency in general surgery at VA Hospital in Des Moines.

Dr. William C. McCabe, Bettendorf, has been appointed by Governor Robert Ray to two-year term on Iowa's new Commission on Alcoholism. The new Commission replaces two former state units concerned with alcoholism. . . . Dr. Deepak Midha, surgeon, is new staff member at the Creston Medical Clinic. A native of India, Dr. Midha graduated from the Prince of Wales Medical College in Patna, India, and received his degree in surgery at Patna University. Prior to coming to the United States, Dr. Midha spent 16 months doing orthopedic and general surgery in England. For the past year he has been a surgeon at Huron Hospital in Cleveland, Ohio. . . . Dr. R. M. Quetsch, Cedar Rapids, spoke on "Diabetes— What It Is," at recent meeting of East Central Diabetes Chapter in Cedar Rapids. . . . Dr. Joseph C. Torbert has joined Dr. J. P. Trotzig in practice at Akron. For the past year, Dr. Torbert has assisted Dr. Trotzig on a part-time basis. A native of Perry, Dr. Torbert received the M.D. degree at Creighton University School of Medicine in 1971 and served his internship and residency at St. Joseph's Hospital in Omaha. . . . Dr. Thomas E. Corcoran, Des Moines, has been named chief of staff at VA Hospital in Des Moines. Dr. Corcoran received the M.D. degree at U. of I. College of Medicine in 1938 and completed his postgraduate work at St. Mary's Hospital in Kansas City and University Hospitals in Iowa City. Dr. Corcoran has been serving as chief of laboratory services at Des Moines' VA Hospital.

Dr. Donald J. Lulu, Des Moines, has joined the Department of Surgery at the Kersten Clinic in Fort Dodge. For the past 22 years, Dr. Lulu has been on the VA Hospital staff in Des Moines and has served as assistant chief of surgery and associate chief of staff for research. A 1949 graduate of University of Illinois College of Medicine, Dr. Lulu interned at Illinois University Hospitals and completed his surgical residency at Des Moines' VA Hospital. . . . Dr. Jack L. Crain has become associated with Dr. David W. Wetrich in the practice of obstetrics and gynecology in Ottumwa. A graduate fellow of U. of I. College of Medicine, Dr. Crain will continue as assistant professor in gynecologic endocrinology and infertility at U. of I. Dr. Crain received the M.D. degree at University of Arkansas in 1966, interned at National Naval Medical Center at Bethesda, Maryland and took his residency at U. of I. . . . Dr. Kim P. Petersen has entered family practice with Drs. R. F. Frech and Dale Onnen at Medical Associates in Newton. A native of Waterloo, Dr. Petersen received the M.D. degree at U. of I. College of Medicine in 1972. He was an intern and resident in family practice at Broadlawns Hospital in Des Moines. . . . Dr. Lawrence Ely, Des Moines, was guest speaker at recent area meeting of Christian Churches hosted by Central Christian Church in Marshalltown. Dr. Ely spoke on his recent experience in Haiti as volunteer missionary doctor at Albert Schweitzer Hospital. Dr. Ely was head surgeon during his stay in Haiti and was on duty 16-18 hours a day.

Dr. Martin E. McKenney, formerly of Las Vegas, New Mexico, joined Lake City's McCrary-Rost Clinic in August. Dr. McKenney, a radiologist, will divide his services between the clinic, Steward Memorial Hospital and Loring Hospital in Sac City. . . . Dr. G. T. Schmunk, Clinton, was recently appointed to fill vacancy on Clinton Com-

### Alcoholism Director

Develops and administers a comprehensive program for the treatment and prevention of alcoholism in the State of Iowa.

Minimum Qualifications: Any combination of education and/or experience equivalent to graduate level course work in hospital, business, behavioral science, public administration, or health areas (medicine, pharmacy) and five (5) years of general administrative experience, two (2) years of which involved administering a drug treatment program or health care treatment facility.

Salary: \$18,960-\$26,664 annually

Contact: Merlin Lee, Personnel Officer
Iowa State Department of Health

Lucas State Office Building
Des Moines, Iowa 50319
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munity School Board. . . . Dr. Chester McClure, Decorah psychiatrist, returns to Indiana, his native state, September 1, to accept a new position as director of LaPorte County Comprehensive Mental Health Center in LaPorte, Indiana. Dr. Mc-Clure came to Decorah as medical director of Northeast Iowa Mental Health Center and later practiced private psychiatry in the Winneshiek County Memorial Hospital. Dr. McClure provided medical and psychiatric service for residents of the County Care Center and also the Allamakee County Home in Waukon. He has served as a member and briefly as chairman of IMS Committee on Alcoholism. . . . Dr. Thomas Ericson, who specializes in ear, nose and throat surgery, facial plastic surgery and head and neck surgery, recently opened practice in Des Moines. Dr. Ericson received the M.D. degree at the University of Kansas School of Mdicine in Lawrence, Kansas. . . . Dr. J. E. Ives, orthopedic surgeon, has joined Medical Associates in Clinton. Dr. Ives recently completed his residency in orthodepic surgery at St. Luke's Hospital in Cleveland, Ohio.

**Dr. Terrence J. Allen,** radiologist, has joined the staff of the McFarland Clinic in Ames. Dr. Allen received the M.D. degree at U. of I. College of

Medicine and served his internship and residency in radiology at University Hospitals in Iowa City. . . . Dr. and Mrs. Martin Schaeferle, Eagle Grove, were recently honored at a farewell dinner at Clarmond Country Club in Clarion, hosted by the Wright County Medical Society. Dr. and Mrs. Schaeferle left in August for their new home in Chapel Hill, North Carolina.

Dr. R. L. Gorrell has closed his Clarion practice to relocate in Phoenix, Arizona. . . . Dr. Jerry A. Kreiter recently joined the Bluff Medical Center in Clinton. A Davenport native, Dr. Kreiter was graduated from U. of I. College of Medicine and interned at the Gunderson Clinic and Lutheran Hospital in LaCrosse, Wisconsin. Following an internal medicine residency at University of Michigan Hospitals, Dr. Kreiter served two Army years in Germany. . . . Dr. William S. Markham, Harlan, was commencement speaker for LPN graduates at Iowa Western Community College. . . . Dr. E. E. Gamet, Lamoni, has been re-elected president of Iowa State Board of Health. He has been on the Board since 1964. Dr. Paul M. Seebohm, Iowa City, was elected vice-president. . . . Dr. George Spellman, Sioux City, and the renal dialysis unit at St. Vincent Hospital, recently received a distinguished service award from the Kidney Foundation of Iowa.

### **DEATHS**

Dr. Harold O. Gardner, 75, Waterloo ophthal-mologist, died July 26 at Schoitz Memorial Hospital of complications following surgery. Dr. Gardner received the M.D. degree at U. of I. College of Medicine and had practiced in Waterloo since 1928. He was a member of Iowa Medical Society and American Medical Association.

Dr. Frederick L. Wahrer, 86, Marshalltown, died August 3 at Community Hospital East in Marshalltown. Following his graduation from U. of I. College of Medicine, Dr. Wahrer located in Marshalltown and practiced there until his retirement. He was a past president of American Congress of Rehabilitation Medicine, member of International College of Surgeons, Life Member of Iowa Medical Society and American Medical Association.

**Dr. Francis B. O'Leary**, 68, Spirit Lake, died August 14 at a Spirit Lake Hospital. A graduate of Creighton University School of Medicine, Dr. O'Leary practiced medicine in Sibley for 41 years before retiring. He was a member of Iowa Medical Society and American Medical Association.

# respond to one

According to her major nptoms, she is a psychoneuic patient with severe ciety. But according to the cription she gives of her lings, part of the problem y sound like depression. is is because her problem, lough primarily one of exsive anxiety, is often accomnied by depressive symptomlogy. Valium (diazepam) provide relief for both—as excessive anxiety is reed, the depressive sympis associated with it are also en relieved.

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Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An h.s. dose added to the b.i.d. or t.i.d. treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, et al: Dis Nerv Syst 30:675-679, Oct 1969. 2. Hollister LE, et al: Arch Gen Psychiatry 24:273-278, Mar 1971. 3. Claghorn J: Psychosomatics

11:438-441, Sept-Oct 1970.



# Valium<sup>®</sup> (diazepam) 2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

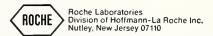
eillance because of their predisposito habituation and dependence. In mancy, lactation or women of childing age, weigh potential benefit nst possible hazard.

ropics or anticonvulsants, consider fully pharmacology of agents emed; drugs such as phenothiazines, otics, barbiturates, MAO inhibitors other antidepressants may potentiate ction. Usual precautions indicated in ents severely depressed, or with latent ession, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



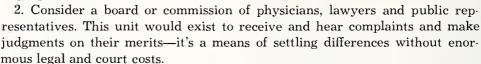
# President's Page

On professional liability. The gradual (and often explosive) escalation of our office expenses is disconcerting. We must increase fees or boost production to stay even. We get so occupied with patients we overlook mounting costs until we are suddenly hit with a 50% or more increase in professional liability insurance premium. We seem to be at the mercy of the carrier even to being cancelled for unknown reasons.

AMA President Malcom Todd told Indiana's House of Delegates last month that professional liability is an AMA priority concern. He had three suggestions to help alleviate problems.

1. Educate yourselves, your hospital and office personnel, everyone who has a patient contact. Stress the importance of liability and teach methods.

ods of prevention. Demonstrate genuine concern for patients—consider them as people, not disease entities.



3. Urge legislators to view this as a public problem and a key factor in increasing health care costs. Study legislation to reduce nuisance or unfounded suits, e.g., if plaintiff lawyers were required to post bond before filing a liability suit they might be more willing to accept the arbitration approach. Legislation could establish such authority.

Your IMS Medico-Legal Committee, chaired by C. H. Denser, Jr., M.D., is working on the many aspects of this problem.

Sincerely,

Ralph R. Wicks

Ralph L. Wicks, President

# IOWA Medical Miscellany

**CONSUMER CREDIT CODE...** New Iowa Consumer Credit Code has some applicability to physicians, according to IMS legal counsel. Areas of involvement include (1) collection procedures, and (2) accounts paid in installments. See page 465 for further information. Interested IMS members may obtain the full legal opinion by contacting Society headquarters.

THINK SESSION... IMS Board will undertake day-long "think session" November 13 to evaluate Society goals and programs. The Board members will try to look ahead to IMS, circa 1984, at the organizational structure, relations with Blue Cross/Blue Shield, the Iowa Foundation for Medical Care, specialty groups, unions, allied health professions, etc. Written input for the 11/13 session has been sought from the House of Delegates and others. Conclusions and/or recommendations emanating from the November session and any others will be presented to the House next April.

COVERAGE CHANGE . . . Blue Cross/Blue Shield has advised as of 1/1/75 nervous and mental health benefits under the long-standing IMS group coverage will be reduced from 365 to 30 days. The change is not applicable to the new and broad BC/BS coverage offered initially in 1974. Open enrollment in the new program, which includes major medical benefits up to \$250,000, continues until December. Contact the Society for more info.

DUES BILLING . . . 81 county medical societies will utilize IMS dues billing services in 1975. Cerro Gordo, Woodbury, Cass and Franklin are recent additions to the list.

**ELECTED** . . . John H. Sunderbruch, M.D., Davenport, was elected one of three regional vice presidents of the American Association of Foundations for Medical Care at the organization's recent national convention.

GUIDELINES . . . Preliminary draft of "Guidelines for Medical Practice Agreements in Iowa" has been furnished the IMS Board by legal counsel. Board reaction to the document is most favorable. Further review has been requested by a special committee and the AMA prior to anticipated membership distribution.

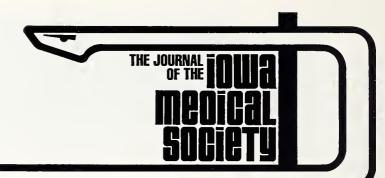
BLUE SHIELD OFFICERS . . . C. E. Radcliffe, M.D., Iowa City, has moved from president to chairman of the Board of Blue Shield to succeed S. P. Leinbach, M.D., Belmond. E. E. Linder, M.D., Ogden, is new president.

SPECIAL COMMITTEE . . . Appointment of special committee to evaluate the Blue Shield UCR program has been approved by the IMS Board. Such action has been urged by IMS Subcommittee on Medical Review and BS Medical Advisory Committee after joint review of April House action calling for BS to make available customary fee profiles to county societies and individual physicians on request.

**PSRO UPDATE . . .** Summary of Iowa PSRO status is contained in recent letter to member physicians from Society President R. L. Wicks, M.D. Opinion was asked of IMS members regarding Foundation performance as Iowa PSRO.

NEW DESIGNATION . . . Tina Preftakes, IMS administrative staff member since 1952, has new title as assistant executive vice president (administration). The new designation was approved by the Board in late September. Ms. Preftakes was formerly assistant to the executive vice president. Eldon Huston is assistant executive vice president (operations). Both serve under IMS Executive Vice President D. L. Taylor.

LICENSING . . . A legislative interim committee is developing legislation that would (1) permit professional and occupational licensing boards (Please turn to page 486)



VOL 64 No. 11 NOVEMBER, 1974

TABLE OF CONTENTS	SPECIAL DEPARTMENTS
Estimation of Bone Marrow Iron Stores—A Comparison of Smear and Section Techniques Mary Ott, M.T. ASCP, D. T. Kaung, M.D., and J. A. Koepke, M.D.  Skin Cancer in Iowa Edward E. Mason, M.D., Mary Nance, Christian E. Radcliffe, M.D., Joseph Scotto, and John W. Berg, M.D.  Zollinger-Ellison Syndrome Yechiel Prusak, M.D., and Edward J. Drew, M.D.  473	In the Public Interest
	MISCELLANEOUS
	Iowa Consumer Credit Code 465
EDITORIALS	4.4% Allergic
Thanksgiving	Continuing Education Courses and Conferences 478

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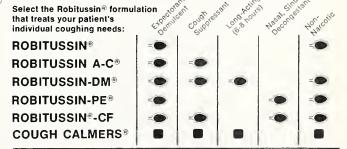
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### State Department of Health

### INFLUENZA VACCINE SEASON

Mid-November is the recommended deadline for completing the annual immunization of highrisk persons against influenza. Routine annual immunization is strongly recommended for all persons aged 65 and over, as well as younger persons who have chronic cardiac, bronchopulmonary, renal, and metabolic disorders. Other persons are not routinely candidates for influenza vaccine. With the highly purified vaccines currently licensed in this country, a single dose confers adequate benefit. The antigenic constituents of the vaccines are reviewed constantly and changed when necessary to insure maximum efficacy against the virus strains expected to be prevalent during the impending "influenza season." The 1974-75 vaccines include a type A antigen comparable to this year's expected "Port Chalmers," and a type B antigen comparable to last year's "Victoria/Hong Kong" strains.

Recent news reports predicting a "new and more deadly" form of influenza this year reflect a misinterpretation of normal epidemiologic patterns for types A and B influenza outbreaks. Type B characteristically affects younger populations than does A, and therefore may not be associated with the excess mortality among aged and infirm persons which is so characteristic of type A epidemics. In terms of "excess mortality," a "Port Chalmers" type A epidemic during the impending season would be expected to exceed last year's "Victoria/Hong Kong" type B mortality and in this sense was reported in the lay press as "more deadly." There is no indication that the "Port Chalmers" strain is any more virulent or deadly than its type A "England," "Aichi," or "Hong Kong" predecessors.

The latest advisory statement of the U. S. Public Health Service relative to influenza vaccine for the 1974-75 season presents concise epidemiologic background and specific usage recommendations for influenza vaccination. It also describes the nature of the current vaccine.

# RECOMMENDED INFLUENZA VACCINE PRACTICES

Some influenza occurs in the United States every year, but there is great variation in its incidence and geographic extent. Periodically, influenza becomes epidemic. This appears to occur when antibody levels wane or when the antigens of prevalent influenza viruses have changed sufficiently to render the population susceptible. Epidemics caused by type A influenza viruses are more frequent and are generally more severe than those caused by type B.

Inactivated influenza vaccine, the best available means of protection against influenza, has been variably effective, and vaccine-induced antibody appears to be relatively short-lived. Consequently, public health recommendations on influenza immunization in the United States are oriented toward protecting those at greatest risk of serious disease and death by emphasizing the selective vaccination of "high-risk" groups.

Repeated observations during influenza epidemics indicate that mortality is almost completely restricted to the chronically ill and the elderly, especially those persons over age 65. Epidemics caused by type A influenza viruses, but rarely

those caused by type B, are notable for inducing mortality in excess of what is normally expected.

Annual vaccination of the "high-risk" group is urged as routine medical practice regardless of the amount of influenza expected in any specific geographic area. In this way, those at particular risk can maintain the highest possible level of protection. Selective vaccination of the "high-risk" group should be emphasized by public health authorities in view of the finding in surveys on immunization that only 10-15% of this group are vaccinated each year.

Influenza control through widespread vaccination of the general population is not currently a public health objective for several reasons: the variable effectiveness and short-lived antibody levels with available influenza vaccines; the relatively low attack rates of influenza in community outbreaks; and the low frequency of serious complications from the disease in healthy people in the general population.

### INFLUENZA VIRUS VACCINE

### Bivalent Vaccine\*

The Bureau of Biologics, Food and Drug Administration, reviews influenza vaccine formulation regularly and recommends reformulation with contemporary antigens when indicated. Bivalent influenza vaccine this year will contain a new type A influenza virus representative of currently prevalent "England" strains. Each adult dose of the 1974-75 vaccine will contain not less than 1200 chick cell agglutinating (CCA) units of antigen in the following proportion: 700 CCA units of a type A strain comparable to the prototype, A/Port Chalmers/1/73 (H3N2)\*\* and 500 CCA units of a type B strain, B/Hong Kong/5/ 72. Vaccines from all producers are highly purified and should be relatively free from significant adverse reactions. Minor reactions such as erythema and tenderness at the injection site and lowgrade fever can be expected to occur occasionally.

### VACCINE USAGE

### General Recommendations

Annual vaccination is strongly recommended

\* Official name: Influenza Virus Vaccine, Bivalent.

for persons of all ages who have such chronic conditions as 1) heart disease of any etiology, particularly with mitral stenosis or cardiac insufficiency; 2) chronic bronchopulmonary diseases, such as asthma, chronic bronchitis, bronchiectasis, and emphysema; 3) chronic renal disease; and 4) diabetes mellitus and other chronic metabolic disorders.

### Annual Vaccination

Annual vaccination is recommended for older persons, particularly those over age 65 years, because influenza outbreaks are commonly associated with excess mortality in older age groups.

Vaccination may also be considered for persons who provide essential community services if local priorities justify. However, before undertaking such an immunization effort, those responsible should take into account a number of reasonable constraints: difficulties inherent in predicting influenza epidemics, variability in vaccine effectiveness, cost, and availability of vaccine.

Vaccination of patients not at "high risk" in an attempt to reduce their chances of acquiring influenza is a decision for practicing physicians. The foregoing discussion of influenza and influenza vaccine may be useful in helping to judge the relative merits of vaccination.

Pregnancy is not an indication for influenza vaccination.

### Schedule

The primary series of bivalent influenza vaccine has traditionally been 2 doses. Data indicate that with the more potent influenza vaccines available in recent years, the second dose provides little additional benefit. It is, therefore, reasonable to give a single dose of vaccine for either primary or annual booster vaccination. (Dose volumes for adults and children and the recommended route of administration are specified in the manufacturers' package labeling.)

Influenza vaccine should be administered by mid-November.

### Precautions

Influenza vaccine is prepared from viruses grown in embryonated eggs and should not be administered to persons clearly hypersensitive to egg protein, ingested or injected.

<sup>\*\*</sup> The World Health Organization has recommended a revised system of nomenclature for type A influenza viruses which includes their strain designation and a description of the 2 surface antigens, hemaglutinin (H) and neuraminidase (N).



### The Question Box

by ROBERT E. RAKEL, M.D.

Dr. Rakel has been professor and head of the University of Iowa Department of Family Practice since January 1971. His answers indicate the progress made in four years.

# What is the status of the Department of Family Practice? What progress has been made?

The four years since I joined the Department as chairman have been rewarding and full of stimulating and satisfying experiences. The Department has grown to 7 full-time faculty members with a large variety of support personnel. Our curricular activities include involvement with medical students in each of their four years; we are helping to develop the growing network of residency programs in Iowa; continuing education activities for the practicing family physician are made available through the Department; and we are actively involved in the development of educational and experimental models in health care delivery in communities such as Muscatine, Williamsburg, Oakdale and one planned for southwest Iowa. A real source of satisfaction has been the opportunity to work with other University faculty, who are outstanding teachers and physicians recognized nationally as leaders in their fields. Our faculty began with a nucleus of experienced and well-qualified family physicians. It has been strengthened by joint appointments with specialists in other departments and outstanding individuals in the field of research and the allied health professions.

### Is the FP program developing satisfactorily?

I must respond with a qualified "yes." Our program is developing rapidly, but we are not near the point where we can begin to correct the severe deficit of family physicians—both in Iowa and nationally. My greatest satisfaction has resulted from the excellent support of Iowa physicians and communities in forming our network of

Affiliated Family Practice Residency Programs. Although our Statewide System is developing beautifully, there is still a significant need to improve our educational program in all locations. Insufficient contact between our faculty and the medical students within the University Medical Center remains a problem as well; but one we hope to correct soon with the opening of a Family Practice Center within the Health Sciences Campus.

### Is Family Practice still increasing in its appeal?

Not only is the number of students interested in Family Practice steadily increasing, but programs throughout the country are now attracting the best students. Insistence upon quality educational programs, coupled with the enthusiastic, bright young men and women being attracted into the field ensure that the momentum toward Family Practice will be maintained and strengthened.

# Do the Family Practice residency programs evolving in Iowa constitute a favorable training progression from your perspective?

I am very proud of the Statewide System and the communities in which these programs are developing. We now have University Affiliated Family Practice Residency Programs at St. Joseph Mercy Hospital, Mason City; Broadlawns and Iowa Lutheran Hospitals, Des Moines; and St. Luke's-Mercy Hospitals, Davenport. New programs are also developing in Sioux City and Waterloo. We have progressed from 8 Family Practice residents in training in 1971 to 72 at the present time. When all programs are fully operational, and including the Cedar Rapids program, there will be 174 residents in training in Iowa. In spite of this rapid growth, and assuming all residents in training remain in Iowa to practice, we will not reach a ratio of one Family Physician per 2,500 population in the State until after 1985.

# Estimation of Bone Marrow Iron Stores – A Comparison of Smear and Section Techniques

MARY OTT, M.T. ASCP, D. T. KAUNG, M.D., and J. A. KOEPKE, M.D.

IRON DEFICIENCY is considered one of the most common organic disorders affecting mankind.¹ Women, children and the elderly are especially vulnerable. The earliest sign of deficiency is manifested by a decrease or absence of storage iron in the bone marrow. This is followed by a decrease of serum iron, an increase in the total iron binding capacity and eventually clinical and laboratory evidence of anemia.² Although it is still uncertain whether iron deficiency without anemia produces any clinical illness, early detection of iron deficiency often provides important clues and confirmation of malignant or benign disorders which contribute to the deficiency.

This paper is submitted by the Bone Marrow Laboratory, Medical Service, Veterans Administration Hospital, Iowa City, and the Departments of Internal Medicine and Pathology in the University of Iowa College of Medicine. Dr. Kaung is a staff physician at the VA Hospital, and an associate professor in the U. of I. Department of Internal Medicine. Dr. Koepke is a clinical pathologist at the VA Hospital and a professor in the U. of I. Department of Pathology. Dr. Kaung is now serving at the VA Hospital in Des Moines.

Agreement existed in 92% of 252 bone marrow specimens evaluated for iron stores both by smears and sections. The authors urge some estimation of iron stores be done routinely in all bone marrow exams.

Numerous articles have been published describing methods for evaluation of bone marrow iron stores.<sup>3–10</sup> Some authors have found bone marrow sections to be the most reliable because of the undisturbed marrow architecture, higher sensitivity and lesser confusion from artefact.<sup>11–14</sup> Others have preferred to use bone marrow smears citing the importance of the percentage of sideroblasts and small iron particles in the R-E cells detectable under oil immersion examination.<sup>15–17</sup> Only one study compared the two methods and the authors concluded neither method could with certainty be regarded as superior to the other.<sup>18</sup>

This report presents the results of the comparison of the two methods in the estimation of storage iron in the bone marrow.

### MATERIALS AND METHODS

Bone marrow smears and sections were prepared as follows: <sup>19</sup> A large (approximately 10

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF NOVEMBER, 1974.

inch square) plastic plate and several standard microscope slides are laid out on a bedside stand. Approximately ½ to 1 ml of marrow is obtained by vigorous withdrawal into a syringe. The syringe is quickly handed to the technologist who expels the entire specimen onto the plastic plate. Smears are made by dipping the end of a pusher slide into the marrow specimen and spreading the sample smoothly across a clean slide. After several smears have been made the remaining marrow is allowed to clot. The clotted marrow is then gathered up on two round wooden applicator sticks and rolled around on the plastic plate until virtually all blood has separated from the small button of marrow particles. The clot is then placed into a tube of formalin and processed with routine surgical specimens. The following morning four sections are cut at different levels in the paraffin block. Two of the sections are stained with H&E and two are stained for iron by the Gomori Method<sup>20</sup> using equal parts of 2% HCL and 10% Potassium ferrocyanide for 30 minutes and counterstained 5 minutes in Nuclear Fast Red.

After drying, the bone marrow smears to be used for iron evaluation were fixed for 10 minutes in absolute methanol, then stained for 30 minutes at room temperature in equal parts of 2% HCL and 2% Potassium ferrocyanide and then counterstained one minute with 0.1% Safranin.

All smears evaluated must contain at least one good marrow particle and all sections two or more marrow particles. Estimation of the iron stores in the smears and sections were performed independently. Smears were examined first under low power to check for iron in the particles and the R-E cells, then with oil immersion to check for the presence and the type of sideroblasts. Iron stores were graded as: no stainable iron found (0); decreased, a small amount of hemosiderin in the particle (-); normal, a good amount of hemosiderin distributed evenly throughout the particles and usually a few hemosiderin containing R-E cells (N); and increased, a heavy amount of hemosiderin throughout all particles and many R-E cells heavily laden with hemosiderin (+). Sections were examined first under low power for heavy deposits of hemosiderin and then under 45× (high-dry) for finely dispersed hemosiderin granules. Iron stores were graded using the same criteria.

### **RESULTS**

In the period from October 1, 1971, to December 31, 1972, a total of 377 bone marrow aspirations were performed at the VA Hospital, Iowa City, Iowa. Of these, 73 were repeat marrows on patients with disorders other than anemia and were excluded from our study to eliminate duplication. Of the 304 remaining, 52 had either no bone marrow specimen for section or were otherwise inadequate in quality for evaluation.

Estimation of the iron stores of the remaining 252 are as follows:

Smear	Section	No.	%
0	0	38	15.1
0		6	2.4
_	0	10	3.9
_	_	35	13.9
-	N	0	0
Ν	-	4	1.6
N	N	98	38.9
Ν	+	0	0
+	N	0	0
+	+	61	24.2
		252	100.0

The smear and section evaluations agreed perfectly in 232 (or 92%) of the cases. The smear estimate was one grade higher than the section estimate in 14 (or 5.6%) and lower in 6 (or 2.4%) of the cases. In no case was there a discrepancy of more than one grade (e.g. 0 and N). In the 20 cases in which there was a discrepancy of one grade, a review of the patients' charts was of little help in ascertaining the true status of the marrow iron. The majority of the patients with any combination of 0 and - reading who received iron therapy responded by an increase of their hemoglobin and hematocrit levels thereby supporting the diagnosis of iron deficiency. The lack of a clear-cut response to iron therapy in others suggests the presence of associated conditions such as malignancy, infection and renal failure which depress erythropoiesis.

Both of the methods are relatively easy to perform and are readily available in any laboratory. Artefacts have been a minor problem mainly occurring in the sections as small chunks of blue filmy substance which can be easily distinguished from the granular blue hemosiderin with a little experience. Occasionally in the smears the counterstain would leave a reddish precipitate which gives the smear a "dirty" appearance but is not readily confused with the blue hemosiderin.

#### SUMMARY

Estimation of iron stores by both smears and sections were done on 252 bone marrow specimens. There was complete agreement in 92% of the cases studied. Minor degrees of disagreement occurred in 8% of the specimens. Review of the clinical courses in these patients did not reveal a clear-cut superiority of one method over the other.

Because of its simplicity coupled with the relatively frequent occurrence of iron deficiency, some estimation of iron stores should be routinely done on all bone marrow examinations.

### REFERENCES

The references noted in this article are available on request from either the author or the Journal of the Iowa Medical Society.

## Iowa Consumer Credit Code

The new Iowa Consumer Credit Code is a lengthy and complicated law. It covers the whole area of credit extended to individuals for, in the words of the statute, "personal, family, household or agricultural purposes."

A legal opinion has been prepared for the Iowa Medical Society which discusses those portions of the law of particular significance to physicians. Following are six conclusions drawn from the full opinion:

- 1) A physician whose total charge is the same, whether the patient pays cash or is extended credit on a customary "open account," is not covered by the Iowa Consumer Credit Code except as to (a) collection procedures; and (b) accounts that are paid in "installments."
- 2) All physicians are subject to that part of the law which prohibits approximately 28 collection practices and procedures, some of which have been considered acceptable heretofore. In general, the physician and his employees should discuss or correspond with a patient concerning his bill in discreet, polite and confidential terms. All communications should be addressed solely to the patient and not even to the patient's spouse without the patient's consent or unless the spouse inquires. If it is known that the patient has retained an attorney in connection with the matter, all communications should be had with the attorney and not with the patient. Any physician desiring to go beyond these suggestions should obtain competent advice or should turn the bill over to a reliable collection agency.

- 3) The law appears to be technically applicable to any arrangement whereby the patient is permitted to make payments in installments even though no additional charge is made for this privilege. However, in cases where there is no "finance charge," a simple "disclosure statement" (which is set forth in the memorandum opinion) will comply with the statute.
- 4) A physician who honors credit cards does not thereby come under the Credit Code.
- 5) A physician who imposes a "finance charge" on a bill delivered to an individual patient thereby comes under all of the provisions of the Iowa Consumer Credit Code pertaining to a "consumer credit sale." This requires him to comply with many technical provisions and requirements of the statute and greatly enlarges his risk of incurring civil or criminal penalties.
- 6) Iowa physicians would be well advised to comply with the present ethics of the profession and to avoid imposing any "finance charge" on an individual patient's account. Even if the Principles of Medical Ethics were to be revised by the AMA to make such action ethically acceptable, Iowa physicians should take into account the problems of compliance with the Iowa law in determining whether or not to impose a "finance charge" in extending credit to patients.

The full opinion on the Iowa Consumer Credit Code is available on request from the Headquarters Office, Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

# The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

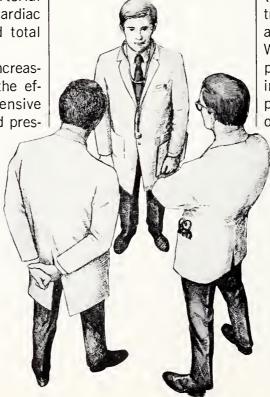
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pres-

sure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions main-

tained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



# Skin Cancer in Iowa

EDWARD E. MASON, M.D., MARY NANCE, CHRISTIAN E. RADCLIFFE, M.D., JOSEPH SCOTTO and JOHN W. BERG, M.D. Iowa City

A SPECIAL SURVEY of skin cancer was conducted in Iowa between September 1, 1971, and February 29, 1972, as part of the Third National Cancer Survey (TNCS). The six-month study was a special attempt to gather information on all skin cancers treated in the State of Iowa and in three urban areas: Dallas-Fort Worth, San Francisco-Oakland and Minneapolis-St. Paul. Reports were requested only for non-melanoma skin cancers.

A larger three-year survey (1969-1971) of all other cancers did not include skin cancer. The methods of case finding used in the TNCS for other cancers were inadequate for skin cancers. Skin cancers are usually not found in hospital records but appear rather in physicians' office records.

The National Cancer Institute survey program is seeking to establish a reliable index to identify the magnitude and nature of the cancer problem. The survey findings contain socioeconomic and epidemiologic implications which form a basis for planning specific research and control programs.

The skin cancer study nationally was planned and supervised by two dermatologists, Urbach and Kopf. Joseph Scotto assumed responsibility for the overall survey. The Iowa Cancer Information Service, which was originally organized by Buckwalter,<sup>2</sup> conducted the Iowa survey under contract to the National Cancer Institute.<sup>3</sup> The separate Iowa skin cancer survey was directed by Edward E. Mason, M.D., and was supervised by

Recent study shows lowans rank below three urban areas in incidence of skin cancer. Basal cell cancers are more common than squamous even though the ratio declines in later life.

Mary Nance. The cancer survey is now completed. However, there has been a reorganization and a continuation of this effort with the establishment of a Cancer Epidemiologic Research Center to monitor the incidence of cancer in Iowa. The Center is being directed by John W. Berg, M.D., who is a new member of the University of Iowa Department of Preventive Medicine.<sup>1</sup>

In advance of the skin survey, a letter was sent to 2,500 Iowa physicians explaining the project. With the letter was sent a return card on which they were asked if they treated patients with skin cancer and, if yes, whether they saw more than 25 patients with skin cancer per year. Nearly 800 physicians returned the postcard. Those who said they treated more than a trivial number of skin cancers were asked to identify on a one-page form the patient, date of diagnosis and type of lesion. The site of the lesion was requested on a map of the front and back of the body which included also both sides of the head and neck. Radiologists and pathologists were consulted in hospitals and in private laboratories in Iowa and in some instances in surrounding areas where Iowans might have been treated or where their specimens might have been processed. Twenty-three dermatologists, 54 surgeons, 131 general practitioners and nine private pathology laboratories contributed data to this study. Hospital pathology labs also furnished information.

The Iowa findings were combined at the National Cancer Institute with similar data from Dallas-Fort Worth, San Francisco-Oakland and Minneapolis-St. Paul. Iowa was the single statewide entity surveyed, its selection based on the presumption that rural living affords heavy expo-

This work was supported in part by contract number NIH-NCI-E-69-42, Biometry Branch, National Cancer Institute.

Dr. Mason is a member of the Department of Surgery, Dr. Radeliffe is in the Department of Dermatology, and Dr. Berg is in the Department of Preventive Medicine, all at the University of Iowa College of Medicine.

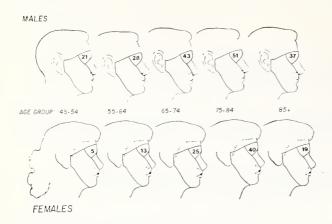


Figure 1. Annual Incidence of Skin Cancer/100,000 Iowans by Selected Site (Eye), Age and Sex.

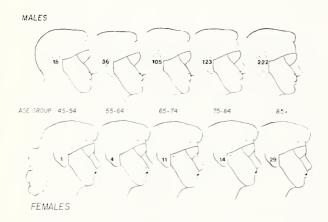


Figure 2. Annual Incidence of Skin Cancer/100,000 Iowans by Selected Site (Ear), Age and Sex.

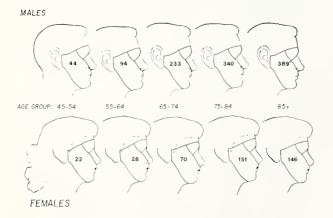


Figure 3. Annual Incidence of Skin Cancer/100,000 lowans by Selected Site (Cheek), Age and Sex.

sure to sunlight. The four areas surveyed include approximately 10 million people or 5% of the United States population. This report is primarily concerned with the data collected in Iowa inasmuch as the results of the national survey will be published elsewhere.<sup>4</sup>

### IOWA LOWER

The incidence of skin cancer in Iowa was lowest among the areas studied and markedly lower than in Dallas-Fort Worth which, because of the southern latitude and arid climate, receives a great deal more sunshine. Unexpected was the finding that Iowans, some of whom work in the fields, have slightly less skin cancer than do people living in the metropolitan areas of Minneapolis-St. Paul and San Francisco-Oakland. The average age of the Iowans who were reported to have developed skin cancer was 67.8 years, or about six years older than the reported average for patients in Dallas-Fort Worth. Multiple cancers were observed in 6.8% of Iowa patients in comparison to 12.5% of Dallas-Fort Worth patients.

The Iowa data does not provide any significant information about the incidence of skin cancer in black people since the black race comprises only 1.5% of the Iowa population. There were only three black patients reported to have developed skin cancer during the six-month survey while there were 1,996 skin cancers reported in Iowans identified as white. There were no skin cancers reported in people under 15 years of age. Among both Iowa men and women the peak age incidence was in the 85 and older age group for both squamous and basal cell cancers. This was in contrast to the other three areas of the United States where peak incidence for males was in the 75-84 age bracket. For women in the metropolitan areas peak age incidence was also in the 85 and over age group.

The predominant cause of skin cancer is exposure to sunlight. The evidence for this has come from a field of study known as clinical dermatologic photobiology, according to Willis. He reports that radiation between 2,900 and 3,200 angstroms, representing about 0.2% of sun rays which reach earth, will produce sunburn damage in human skin.<sup>5</sup>

Besides the geographic differences there are striking differences in the location of skin cancers on the body surface which also indicate the importance of exposure to sunlight. The majority

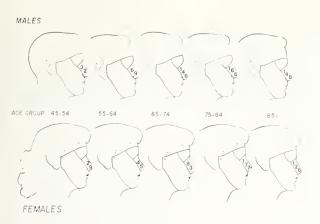


Figure 4. Annual Incidence of Skin Cancer/100,000 Iowans by Selected Site (Nose), Age and Sex.

of cancers are seen in the exposed skin of the face and neck, the back of the hands and the forearms and to a slight extent on women's legs. These data, therefore, show a pattern of distribution which relates to habits of dress, work and play.

The midface is an area of contrasting exposure for adjacent areas and between men and women. The eye (Figure 1) is more protected from sun by the forehead, the eyebrows and eyelashes; the incidence of skin cancer is lower here than for the nose in both men and women. The ear (Figure 2) is protected by women's hair whereas the male ear is exposed to sunlight, unless protected by a hat with wide brim or other cover. The cheek of the woman is protected by a profuse, fine, usually invisible hair and by the use of cosmetics (Figure 3). The male cheek has usually been shaved, removing not only hair but the superficial layers of cornified skin. The nose of both sexes projects into the sunshine and apparently the passing generation of women is using less powder so that particularly in the older age groups, the incidence of skin cancer of the nose is as high in women as in men (Figure 4).

Considering the relatively small surface area of the hand as compared with the trunk, the incidence of skin cancer is high and it is nearly as high in women as in men (Figure 5). The deliberate exposure of the trunk to sunlight for the sake of achieving a pleasant tan has apparently been sufficiently infrequent and with adequate caution so that incidence of skin cancer on the trunk has remained low in both men and women. Cancer of the skin is more frequent on the lower lip than the upper lip and much more common in men than in women. Some of this sexual differ-

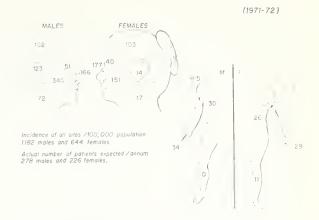


Figure 5. Comparative Incidence of Skin Cancer Among Iowa Males and Females.

ence is undoubtedly due to the frequent use of pigmented lipstick by women.

### BASAL MORE COMMON

Basal cell cancers are much more common than squamous cell cancers at all ages and in both men and women (Table 1). It appears that as skin cancer becomes more common in the older age groups the incidence of squamous cell cancer increases more rapidly than the incidence of basal cell cancer. Men appear to be more susceptible to the development of squamous cell cancer than do women. In early life skin cancers are much more likely to be basal cell. Later in life, with an increasing age related frequency of squamous cell cancers, a final ratio of basal to squamous cell cancers of between 1.6 and 4 was reached for all areas except the nose.

The greatest predominance of basal cell to squamous cell cancers is seen on the nose. The ratio remains high throughout the later years of life in the male. The middle-aged woman who develops a skin cancer on the nose is also likely to have a basal cell cancer. As women pass from middle years into later years of life, there is an increasing likelihood of squamous cell cancer but the ratio of basal to squamous cell cancers of the nose, even in the last decades of life, remains around 6. For the scalp and forehead during the fifth and subsequent decades the ratio of basal to squamous cell cancers in women drops from 10.5 through 6.3, 3.5 to 2.3 and changes from 5.7 to 2.2 to 2.4 for men. The fall is related more to an increase in incidence of squamous cancer on the scalp than a change in basal cell cancer incidence.

These data indicate that over 4,000 skin cancers are now being treated per year in the State of

TABLE I ANNUAL AGE SPECIFIC INCIDENCE RATES AND RATIOS FOR BASAL AND SQAMOUS CELL CARCINOMA IN SELECTED SITES AND FOR ALL SITES FOR WHITE IOWA MEN AND WOMEN

	Scalp, Forehead			Nose			Cheek, Chin, Jaw			All Sites						
	55-64	65-74	75-8 <i>4</i>	85 <del>+</del>	55-64	65-74	7 <i>5-84</i>	85 <del>+</del>	55-64	65-74	75-8 <i>4</i>	85 <del>+</del>	55-64	65-74	75-84	85+
Male																
Basal	62.8	63.9	72.3	111.2	59.7	134.7	148.8	129.7	70.7	184.9	259.4	259.4	290.5	607.1	791.0	833.6
Squamous	11.0	29.7	29.8	_	9.4	13.7	17.0	18.5	23.6	47.9	80.8	129.7	142.9	223.7	340.2	518.7
B/S	5.7	2.2	2.4		6.4	10.0	8.8	7.0	3.0	3.9	3.2	2.0	2.0	2.7	2.3	1.6
Female																
Basal	30.5	68.3	79.7	87.5	42.1	73.7	150.9	106.9	21.8	55.7	113.9	97.2	152.4	293.1	495.6	505.5
Squamous	2.9	10.8	22.8	38.9	2.9	9.0	25.6	19.4	5.8	14.4	37.0	48.6	23.2	77.3	136.7	184.7
B/S	10.5	6.3	3.5	2.3	15.0	8.2	5.9	5.5	3.8	3.9	3.1	2.0	6.6	3.8	3.6	2.7

Iowa. The physician hours and cost of treatment in terms of ancillary help, equipment, office and laboratory space can be estimated. Also, the effect of the increasing age of the population and an increase in population density for any specific age span can be predicted. These are minimal estimates since some skin cancers are not diagnosed and others go unreported in studies such as this. Those involved in the collection and analysis of these data feel the information is extremely valuable, not only in the planning of medical care for our citizens, but in the detection of potential health hazards and in the education of our people so they may reduce their risk of skin cancer, if they wish to do so. Iowa physician cooperation in the survey has been excellent. Proper concern and respect has been shown for the privacy of the individual, and at the same time importance has been attached to the pooling of statistical information about the incidence of cancer and other diseases. This is necessary for a full understanding of the problem of prevention.

## TWICE AS HIGH

The incidence of skin cancer reported in this study is twice as high as previously reported. These data indicate that skin cancer is a serious problem in Iowa as well as in other areas studied and that measures need to be taken to educate our people as to the hazards of excessive and repeated exposure to sunlight, especially those individuals who are light skinned and susceptible to easy burning and severe tanning. Each prolonged exposure of the skin which results in the well known reactions of sunburn and tan will speed up the changes of wrinkling, variations in thickness of the skin, formation of patches of pigment and scaling and will ultimately produce a socalled actinic or senile keratosis which finally, in 25% of individuals, develops into basal and/or squamous cell cancer. Ultraviolet radiation is carcinogenic and, as with other carcinogens, the effect is cumulative. The dosage can be decreased at any time by reducing or eliminating exposure to the source.

Work and play outdoors do not need to be curtailed. An adequate amount of physical exercise is important for health. Skin cancer may be easier to treat than many of the complications of a sedentary, weakened and overweight body. There are, however, excellent ways of protecting exposed areas of skin with wide brimmed hats, clothing other than white fabrics and applications of protective formulations such as para-aminobenzoic acid, zinc and titanium ointments and avoidance of deliberate sun bathing and use of ultraviolet lamps.

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# Zollinger-Ellison Syndrome

YECHIEL PRUSAK, M.D., and EDWARD J. DREW, M.D. Des Moines

THE ZOLLINGER-ELLISON SYNDROME results from excess secretion of gastrin. The hypergastrinemia will cause massive hypersecretion of hydrochloric acid in the stomach. It will result in intractable peptic ulceration. Usually a pancreatic islet cell tumor is found, but this is not true in all the cases.

This report is of a case of Zollinger-Ellison syndrome in which no tumor was found in laparotomy. The patient underwent total gastrectomy and is doing well and is asymptomatic.

### CASE REPORT

A 36-year-old woman was admitted to Iowa Lutheran Hospital in Des Moines, Iowa 5/20/69. Six months earlier she had been hospitalized elsewhere with a duodenal ulcer. She had a subtotal gastric resection with gastrojujenostomy. Her immediate postoperative course was uneventful. Two months later however she developed recurrent abdominal pain, and was admitted to Iowa Lutheran Hospital. Her upper gastrointestinal series revealed a marginal ulcer. Because of the intractibility of her symptoms, and because no vagotomy was performed in the original operation, she was re-operated 6/2/69. At surgery, vagotomy was performed. A large gastric-jejuno ulcer perforated into the liver was resected. She did well for a year, but was readmitted to the hospital 8/71. She was diagnosed as having a marginal ulcer with upper gastro-intestinal bleeding. She was treated conservatively with diet, antacids and anticholinergics with fair results. She was hospitalized three more times with abReported here is a case of Zollinger-Ellison syndrome treated by total gastrectomy even though a tumor of the pancreas or duodenum was not found. Three criteria are cited to determine diagnosis.

dominal pain due to marginal ulcers. In 5/72, gastric analysis revealed hyperacidity, but not in a level compatible with Zollinger-Ellison syndrome. The gastrin level was 1150 pg/ml. (Normal is between 200-500 pg/ml.) In view of the recurrent ulceration, and despite two gastric surgeries, including a vagotomy, she underwent re-exploration for pancreatic tumor. Two marginal ulcers were encountered and the pancreas was searched diligently for evidence of a tumor which would be compatible with the Zollinger-Ellison syndrome. However, no islet cell tumor was found. She had another resection of the ulcer. The benefits of this surgery did not last long and she was hospitalized in five months with abdominal pain.

A psychiatric consultation was undertaken with a diagnosis of reactive depression with marital problems. At this time, Elavil® was added to her therapy. In her last hospitalization the diagnosis of recurrent marginal ulcer was again confirmed by endoscopy, the gastrin level at this time was 2420. A 12 hour overnight gastric analysis was 130 mEq of HCL. Selective celiac and a superior mesenteric arteriogram failed to reveal any tumor. In view of the recurrent ulceration, gastric hyperacidity, and confirming elevated gastrin level (even though no tumor was found in previous surgery), she was re-operated on 7/11/73. At this time, a total gastrectomy was performed and an esophago-jejunostomy was established in addition to a jejuno-jejunostomy. Again, the pancreas was diligently searched for a tumor and none could be demonstrated.

Following the removal of the entire stomach, the patient recovered after a somewhat stormy postoperative course. She has gained weight since and is able to function with three meals a

Dr. Prusak is a private practitioner specializing in gastroenterology. Dr. Drew is in the private practice of surgery. Both practice in Des Moines, Iowa.

day. Her diarrhea complaint has been controlled with Lomotil,<sup>®</sup> and her flatulence has been controlled with bile salts. After one postsurgical year she is doing well without any recurrence of pain or ulceration.

### DISCUSSION

Various criteria for the diagnosis of the Zollinger-Ellison syndrome have been suggested, based on the acidity or acid output of unstimulated or stimulated gastic secretion, as well as on various secretory ratios. A basal acid output of more than 15 mEq/h in the unoperated, or more than 5 mEq/h in the operated stomach; or a 12 hour overnight secretion of more than 100 mEq is considered diagnostic of Zollinger-Ellison syndrome. However, these criteria may give a false positive or a false negative diagnosis, and therefore, the diagnosis depends on radioimmunoassay of serum gastrin level.

Our patient had a typical history of Zollinger-Ellison syndrome with recurrent peptic ulceration. However, she did not have definite therapy until 1973. The delay was caused by initial unavailability of serum gastrin level determinations. Bioassays have been used to demonstrate gastrin activity in the serum since 1964. However, this method has been available in only a few research centers. Radioimmunoassay of gastrin was reported in 1968, but became commercially available only in the last two years. In 1972, the patient was found to have an elevated gastrin level, but a definite conclusion was not drawn and she did not have a total gastrectomy in her third exploration. Another reason for the delay in definite therapy, i.e., total gastrectomy, was the "normal" acid level when the diagnosis of Zollinger-Ellison syndrome was first entertained. False negative gastric acid output was probably due to improper localization of the nasogastric tube. This can explain the "normal" gastric hydrochloric acid secretions. Only in her last hospitalization was the patient found to have all three criteria confirming the diagnosis of Zollinger-Ellison syndrome: recurrent ulcerations,

# 4.4% ALLERGIC

A 3-year study of 7,765 patients by a research team at the J. Hillis Miller Health Center, University of Florida, Gainesville, found 4.4% of the patients had adverse reactions to the antimicrobial drugs.

gastric hyperacidity and elevated serum gastrin level.

As medical treatment of Zollinger-Ellison syndrome is almost always a failure, all cases should have total gastrectomy. Even a tiny remnant of stomach can produce from its few square centimeters the amount of acid secreted by the intact stomach of a normal person. The survival of Zollinger-Ellison syndrome improved with the extent of the surgery; 87% with total gastrectomy and only 49% with subtotal resection. Most deaths appear to result from shock, bleeding, or an anastomotic leak early in the postoperative period. The most important fact underlying the advisability of total gastric resection at the first operation is that 66% of all patients have more than one site of abnormal gastrin production. Even in children total gastric resection must be carried out if the previously stated criteria are all present. One possible exception to the rule is the patient with Zollinger-Ellison syndrome in whom gastric secretion ceases at surgery after removal of a single isolated pancreatic or duodenal tumor. Gastrinomas usually are small tumors. Both primary and metastatic tumors may be difficult to locate during surgery or at postmortem examination. Benign and malignant gastrinomas may produce identical microscopic findings and the only sure methods of establishing malignancy is demonstration of metastatic spread. Gastrinomas have been reported to originate in the pancreas, the duodenal wall and in the stomach.

It is of interest that patients with pernicious anemia have circulating levels of gastrin as high as a patient with Zollinger-Ellison syndrome. However, the clinical picture is so different that this does not constitute a diagnostic problem. A simple determination of antral pH is sufficient to differentiate the two diseases.

In summary, we have reported a case of Zollinger-Ellison syndrome that justifies the approach of total gastrectomy as treatment even though a tumor of the pancreas or duodenum was not found.

The reaction ratio varied from 0.88% for streptomycin to 8.5% for methicillin. Reaction was moderate or severe in 58% of the observed episodes and hospitalization was prolonged by 45% of the reactions.

The study by J. R. Caldwell, M.D., and L. E. Cluff, M.D., is reported in the Oct. 7 issue of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.



M. E. ALBERTS, M.D., Scientific Editor

# **THANKSGIVING**

November is the traditional month when we give thanks for our blessings and worldly goods. The Pilgrims of the early colonies had much for which to be thankful, yet their blessings were scant by today's standards. Theirs was a new land, a new way of life, new freedoms, though very primitive and hazardous. Each year we celebrate Thanksgiving Day, each in our own way. Some have family traditions wherein all gather at the home of the grandparents for feasting and the renewal of fond memories. Other people look forward to a day away from the office, another football game via television.

Have you ever reflected upon your life and its blessings? Have you honestly expressed your thanks in your own way for your fortunes? Have you looked back upon your life to review the happenings as well as the people responsible in some way for your present state of being? If not, why not? Do you believe such is beneath you? Is your life so busy gathering in your harvest that it did not occur to you, or are you so self-sufficient that you need not give thanks?

Reflection upon the past often brings into focus many of life's important milestones. As I reflect upon people and places, I think with much gratitude about the teachers I had in grade school and high school. I truly wish my children could have been under the guidance of those same dedicated special people. Those wonderful people showed a love for their profession and a devotion to their students. There was a standard of education designed to prepare the child for life, as well as the realization that life had much to offer. Our early days were directed along a pathway of appreciation of the cultural values—art, music, good man-

ners—as well as the academic subjects. Furthermore, we were taught to be self-sufficient. The best results were from self-discipline and working together rather than expecting someone "to hand it to us on a silver platter."

Behind those dear teachers was the dedication to parenthood by a good mother and father, neither of whom had a formal education beyond the eighth grade. Their devotion to insuring that we did right, learning our lessons of life, as well as at school, set the stage for future years. There were no frills; no television; no country clubs; no expensive vacations; no elaborate toys. The basics were there—love in a simple fashion without obvious show of affection, a wholesome life, and dedication to consideration of the family as well as the rights of others. For those lessons I am thankful.

How did you manage the finances of your education? Did your father "pick up the entire tab," or were you of the A.S.T.P. or V-12 vintage? I am sure it must be great to be born "into money" and have no worry about the source of the next dollar, but there is a true feeling of accomplishment in obtaining something by one's own efforts. My thanks, now and forever, go out to a faithful wife and helpmate who helped me through medical school during those long and difficult days at the close of World War II. Fortunately, the G.I. Bill was available to provide the tuition, but certainly not all the necessities. I am even thankful for the meager apartment we occupied, but it was a home.

My wife became the complete bread-winner during the years of internship and residency training. Two definitely cannot live as cheaply as one, when the salary is twenty-five dollars a month. Her compensation as the office nurse of a very kind physician included an apartment above his offices. The people of that small town remain our good friends. For those experiences I am thankful.

During my hospital training years several physicians were instrumental in charting my course. The internist who was ever so kind and considerate to me, and serves as my personal physician has my thanks. I am exceedingly thankful to my chief of pediatrics who so patiently and gently engendered his love of pediatrics to us; also, to all the other physicians who provided the guidance and learning experiences in the true tradition of the Oath of Hippocrates. They extended the fine teachings offered by the professors in medical college. For the efforts of all these people, I am truly grateful.

Now I have a practice that is good. My patients

are good people. My associates are good people. I have a good family. I am proud of my children and my grandchild. For all these, I am thankful.

We live in a nation which stands above all other nations. In spite of political strife we bounce back and remain strong. Many aspects of our heritage remain; progress changes some facets of our society. More changes will come. Yet we go forward with our heads held high, the envy of peoples of other lands who know only strife, hunger and disease. Our strength is in a conviction that life is important, and that our destiny is in the hands of an omnipotent power which may be beyond our clear understanding. But it is there, and for that I also am thankful.

Now, it is your turn. Do your own reflecting. Be humble—be thankful.—M.E.A.

# It is our pleasure to serve as Administrators and Counselors for major Insurance Programs in behalf of the Members of many lowa Association Groups including:

- \* IOWA DENTAL ASSOCIATION
- ★ IOWA ENGINEERING SOCIETY
- ★ IOWA MEDICAL SOCIETY

- ★ IOWA SOCIETY OF OSTEOPATHIC PHYSICIANS AND SURGEONS
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# ATTACK ON MANPOWER SHORTAGE MOVES AHEAD

THE MEDICAL MANPOWER picture—nationally and in Iowa—is brightening. No one is claiming our needs will be fully met next year, the year after, or within a decade. But we are making headway.

The first increase in number of Iowa physicians for 10 or more years was reported recently by the University of Iowa College of Medicine. A 60-doctor hike was disclosed by College officials—from 2,995 in 1973 to 3,055 in 1974. These figures were noted to include physicians in resident programs.

Of further consequence—with the academic year in full swing—is the continuing emphasis on undergraduate medical education. There are reported to be 14,436 first-year students in the nation's 114 medical schools this fall. Total 1974-75 medical school enrollment has been estimated at 53,735 by the American Medical Association.

These record totals demonstrate that significant action is being taken to alleviate medical manpower shortages. In addition to the numerical growth, the broad efforts to stimulate student interest in primary care fields and in geographically-underserved areas are producing results.

There are 650 students at the University of Iowa College of Medicine this fall. Of these, 175 are in the freshman class. These first-year medical students were selected from among 1,477 preliminary applicants and 629 final candidates. There are 163 Iowans in the group.

Is interest in Family Practice continuing to grow at the undergraduate level?

Yes, say College of Medicine officials. They contrast 1967 and 1973: 32 freshmen expressed interest in family practice in 1967; this more than doubled to reach 86 in 1973.

The nationally circulated AMERICAN MEDICAL NEWS visited The University of Iowa College of Medicine recently to interview five new medical students. The September 16 story reported:

"... All five interviewed said they hoped to spend at least a couple of years in programs like the National Health Service Corps, or the U. S. Public Health Service—three specifically mentioned a desire to work for the Indian Health Service.

"All five expressed a preference for family practice or similar primary-care fields. Two specifically said they wanted to practice in rural physician-shortage areas."

Who were the interviewees?

Bill Helm, 24, Cedar Falls, Iowa State graduate where he had three majors, out of school two years working at odd jobs. Said Helm in the AMN interview: "So far, I'm really impressed with med school. There's no competition for grades, and everyone seems to be here to learn. It's a really good atmosphere."

Russ Gabriel, 21, a black who grew up on Chicago's South Side and attended Graceland College, was quoted: "I can remember saying when I was seven years old, 'I want to be a doctor.' I don't know why—and I've thought about it, believe me—but I've never really considered any other career."

Mark McAndrew, 20, medical school applicant after three undergraduate years of biochemistry at the U. of Iowa and a native of Kalona: "The money isn't what I'm interested in. I would like to raise my family in a rural area comparable to where I grew up, or even more rural than that where my kids can meet nature one on one."

Rick Artist, 21, Guthrie Center, farm background, Luther College graduate: "Ever since I said I was going into medicine, people around my home town keep asking me, 'Are you going to come back?' There are towns in this area that have built clinics, without doctors, in the hope they can attract one. I'd like to practice in a rural area, and be a family practitioner—where I'm needed."

Mary Spalding, 21, Iowa City, whose parents are associated with the University: "I would like to work among poor people. And the thought of working on an Indian reservation really appeals to me."

These five medical students are extremely able individuals. They and their classmates will soon respond to vital human needs.

# IN THE PUBLIC INTEREST

# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

# "THE METHOD IS IRRELEVANT"

A New York physician, Leon N. Zoghlin, M.D., recently wrote about physician education: "Competency is our goal. The method by which it is achieved is irrelevant." His second sentence raises some question-marks for me, since I am well-trained to be suspicious of suggestions that ends justify means. But that competency is our goal seems hard to dispute.

The assessment of practitioner competency has long been a difficult and thorny issue. Medical audit and peer review techniques have offered us an opening wedge into that. Common sense and expert opinion (not always mutually exclusive) can also be of help. But once we have means to judge competent performance, we may finally arrive at the happy state of being able to judge more adequately which learning methods are best

for which learners for which tasks, and which methods cost less time and effort from the learner, instructor, and physical setting. Because of the nature of human diversity, multiple methods for learning and gaining competence will always be needed

Better judgment than we've had before, regarding what is good medical practice, will prove beneficial to those who have interest and responsibility for medical education. (But that should mean all physicians, shouldn't it, since each practitioner bears responsibility for continuing and up-dating his medical education.) And such better judgments about standards seem likely to arise in the next several years under the impetus of the present PSRO legislation. Since PSRO is currently an accomplished fact, it's appropriate to maximize those features of it which seem clearly advantageous, such as the educational benefit.

To become well-informed about PSRO and quality-of-care assessment must be a high-priority assignment on every physician's list of what-to-learn-next.

# Continuing Education Courses & Conferences

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

Nov. 6	Ophthalmology Clinicol Conference	Dec. 2-5	Cordiology Todoy
Nov. 7	Whot's New in Stroke	Dec. 4	Whot's New in Stroke
Nov. 8	Postgroduote Conference on Surgery	Dec. 4	Ophtholmology Clinical Conference
Nov. 8-9	Clinical Endocrinology	Dec. 6	Cordioc and Respiratory Disease Conference
Nov. 9	Concer Teoching Doy	Dec. 7	Iowo Clinicol Society of Medicine
Nov. 18-22	Intensive Course in Pediatric Nutrition for Nu- tritionists and Dietitions	Dec. 11-12	lowo Obstetricol and Gynecological Society
Nov. 20-21	Medical ond Nursing Manogement of the Acute Alcoholic	Dec. 11-12	Postgraduate Conference on Obstetrics ond Gynecology

Dr. Caplan is Associate Dean, Continuing Medical Education at The U. of I. College of Medicine.



by TENORA MEYER, CMA

# FROM OUT OF THE WEST

Approximately 850 medical assistants attended the 18th annual meeting of the American Association of Medical Assistants in Denver, Colorado, September 24-29.

Our state president, Joann James, Mason City, attended the convention, along with representatives from each chapter in Iowa. The state presidents met to develop goals for the coming year. The emphasis was on communication and group participation with education, of course, of prime importance.

Two top officials of the American Medical Association headed an impressive list of physicians who shared their expertise. Robert B. Hunter, M.D., Sedro Woolley, Washington, member of the AMA Board of Trustees, discussed the impact of PSRO legislation on both physicians and their assistants. He stressed the important role of the medical assistant as a member of the health team. Malcolm C. Todd, M.D., Long Beach, California, AMA President, extended official greetings at the Inaugural Banquet. Leo E. Brown, Assistant to AMA's Executive Vice-President, served as Master of Ceremonies for this occasion.

Mrs. Betty Lou Willey, CMA-A, Port Huron, Michigan assumed the presidency, succeeding Mrs. Marian G. Cooper, CMA-C, Pittsburgh. Laura L. Lockhart, CMA-A, Akron, Ohio, was chosen President-Elect; Joan Michaels, Charlotte, N. C., Vice President; and Dorothy Hartel, Baltimore, Maryland, Secretary-Treasurer.

Action of the 1974 AMA House of Delegates

commending the American Association of Medical Assistants was reported. The AMA House urged formal support of the AAMA by all state medical societies. This is the fifth time AMA commendation has come to the AAMA.

Two educational lectures were devoted to human relations in the medical office—"Love" by Robert P. Benvenuti, M.D., Denver psychiatrist, and "Patience with Patients" by Jokichi Takamine, M.D., family practitioner from Los Angeles.

A two-part "Miracles of Medicine" presentation was given by Thomas E. Starzl, M.D., Denver, recipient of AMA's 1974 Brookdale award for his work in transplantation and treatment of liver dysfunction, and by Nicholas G. Douvas, M.D., Port Huron, Michigan, who showed films on revolutionary ophthalmological procedures.

"A Shocking Demonstration on Electrical Accidents" was presented by Claude Haggard, international safety expert from Medford, Oregon. He gave a science-oriented presentation showing the effect of electrical shock on the human body.

There was a special workshop for medical assisting educators. Topics included administrative and clinical aspects of a medical assisting curriculum, plus externships. In addition, open-door clinics on accreditation were held.

The mini-test was again offered to the medical assistants attending the convention. The mini-test is representative of portions of the certification examination.

Enthusiastic support by the membership has enabled the Maxine Williams Scholarship Fund to award five scholarships this year rather than the usual three. The AAMA Endowment deposited \$500 with the registrars of each of the recipients' designated schools.

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

# Morbidity Report for September 1974

	_	1974	1973	Most September Cases			1974	1973	Most September Cases
	Septembei		to O-4	Reported From These		ptembe		to	Reported From These
Disease	1974	Date	Date	Counties	Disease ——————————————————————————————————	1974	Date	Date	Counties
Actinomycosis	1	0	1	Woodbury	Influenza-like				
Amebiasis	2	28	75	Floyd, Johnson	illness	2428	91875	11810	Cerro Gordo, Chickasaw
Ascariasis	1	10		Johnson					Madison, Sac
Brucellosis	2	14		Dubuque, Tama	Meningitis, type				
Chickenpox	87	6279	10847	Scattered	unspecified	5	31	26	Dubuque, Johnson, Scott
Conjunctivitis	61	590	84 I	Scattered					Story, Webster
Cytomegalovir	us				Meningitis,				
infection	3	32		Johnson, Webster	aseptic	10	52		Johnson, Polk
Combined					Meningitis,				
infestations	3	4		Muscatine	bacterial	- 1	5		Polk
Echovirus type	4 I	11		Allamakee	Meningitis,				
Encephalitis, ty	/pe				aseptic assoc.				
unspecified	1	14	13	Winneshiek	with ECHO 4	3	12		Polk
Encephalitis, v	iral 3	16		Buena Vista, Linn,	Meningitis, bac-				
•				Winneshiek	terial due to				
Encephalitis du	ıe				Hemophilus				
to California					influenzae	1	4		Polk
virus	1	1	1	Allamakee	Meningo-				
Enteropathoge					encephalitis	3	5	8	Linn, Polk
E. Coli	4	14		Polk, Pottawattamie,	Mumps	53	1670	3100	Des Moines, Montgomery
2. 00.	•	• •		Woodbury	wamps				Sioux, Union
Erythema				vv oodbary	Pediculosis	80	330	130	Black Hawk, Linn,
infectiosum	24	537		Scattered	1 6010010313	•	330		Muscatine, Wapello
Gastrointestina		557		Scattered	Pertussis	1	13		Wapello
viral inf.	1237	6864	5603	Allamakee, Chickasaw,	Pinworms	- 11	52		Cedar, Polk
virai int.	1237	0004	2003	Pocahontas, Sac	Pneumonia	79	711	869	Scattered
C: 1: -:-	,	20	14				106	184	Scattered
Giardiasis	3	38	14	Johnson, Muscatine	Rabies in animal		47	104	Linn, Muscatine,
Guillian-Barré		•		1	Rheumatic fever	3	47		Pottawattamie
syndrome	. 1	9		Lee	D: 1 1	20	127	27	
Hand, Foot, an					Ringworm, body	38	136	27	Scattered
Mouth Disea	se 6	6		Mahaska, Washington	Ringworm, scalp	4	9		Harrison, Marion,
Hepatitis, A	_								Mitchell, Monroe
(Infectious)	15	213	167	Dallas, Johnson, Linn,	Roseola	5	14		Des Moines, Monroe
				Polk	Salmonellosis	31	156	138	Scattered
Hepatitis, B					Scabies	- [1	71	13	Howard, Johnson,
(Serum)	6	69	40	Clay, Dickinson,					Muscatine
				Marshall, Polk, Story	Shigellosis	47	233	235	Black Hawk, Dubuque,
Hepatitis, type					-				Jackson, Scott
unspecified	6	30	18	Des Moines, Hardin,	Streptococcal				
				Polk, Scott	infections	375	7668	5118	Scattered
Herpes simples	( 10	88	49	Clayton, Johnson, Linn,	Tetanus	1	1		Jackson
				Polk, Webster		i	3		Fayette
Herpes zoster	6	36	15	Johnson, Keokuk, Marion,	Trichuriasis	'	3		layerie
				Polk, Warren	Tuberculosis,		-00	00	Carthand
lmpetigo	108	306	282	Linn, Marshall, Story,	new active	8	90	99	Scattered
-				Wapello	Venereal diseases				21 1 1 1 1 1 1
Infectious					Gonorrhea	668	4650	4674	Black Hawk, Johnson,
mononucleos	is 81	723	522	Buena Vista, Johnson,					Linn, Polk, Scott
				Linn, Sac	Syphilis	41	309	324	Linn, Polk, Scott

# raining of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't hink this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce — information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

# Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

### he Other Side of the Coin

Obviously, the pharmaceutial companies are not producing all his material as a labor of love hey are in the business of selling roducts for profit. In this regard he ambitious and improperly motiated sales representative can xert a negative influence on the racticing physician, both by preenting a one-sided picture of his roduct, and by encouraging the ractitioner to depend too heavily n drugs for his total therapy. In hese ways, the salesman has often listorted objective reality and ındermined his potential role as an ducator.

# he Industry Responsibility

Since the detail man must be in information resource as well as representative of his particular pharmaceutical company, he should be carefully selected and

thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

### Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005



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# **About IOWA Physicians**

**Dr. William Erps** has assumed the practice of Dr. J. W. Gauger in Early. Dr. Erps practiced in Storm Lake at one time and more recently has been associated with Veterans Administration at Grand Junction, Colorado. Dr. Gauger was honored recently by Early citizens for his 34 years of service. . . . Dr. Tomas Lopez, Keokuk, is chairman of the Ron Londrie for State Representative Committee. Mr. Londrie is a candidate for State Representative from Iowa's 86th District. . . . Dr. William R. Whitmore, Davenport, has been reappointed by Governor Robert Ray to oneyear term on Physical Therapy Examiners Board. . . . Dr. H. A. Van Hofwegen, Spencer, spoke at a recent training session for volunteer participants in Reach for Recovery program of American Cancer Society. He presented Ciba Medicia slides illustrating latest procedures in treatment of breast cancer. . . . Dr. Gerald C. Sunner, formerly of Fort Dodge, has joined Dr. Frank Edington in family practice in Spencer. A native of Eagle Grove, Dr. Sunner is a 1957 U. of I. medical graduate and interned at Mercy Hospital in Cedar Rapids. He practiced in Fort Dodge for 16 years.

Dr. Philip B. Johnson, an internist, has joined the Gilfillan Clinic in Bloomfield. Dr. Johnson received the M.D. degree at Northwestern University Medical School. He interned at Cook County Hospital in Chicago and completed his internal medicine residency at Cook County Hospital and Emanuel Hospital in Portland, Oregon. . . . Drs. W. H. Kuckes, C. H. Lee and K. A. K. Pai recently entered psychiatric residency training at the Cherokee Mental Health Institute. Dr. Kuckes received the M.D. degree at University of Colorado, interned at St. Anthony's Hospital in Denver and completed a year of psychiatric training at Denver General Hospital. Dr. Lee, a Korean, earned the M.D. degree at Seoul Na-

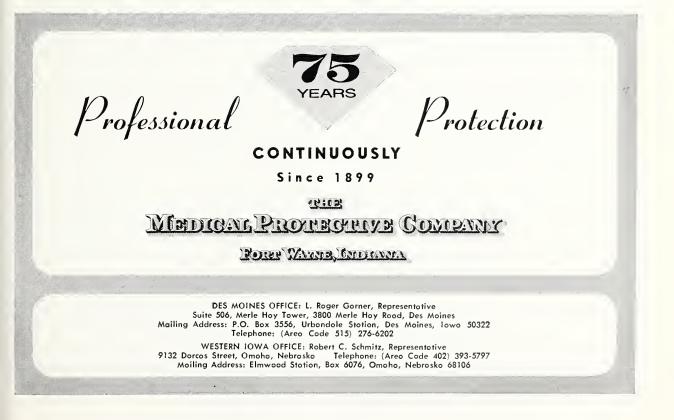
tional Hospital and interned at Shadyside Hospital in Pittsburgh, Pa. Dr. Pai received his medical education at Kasturba Medical College and interned at McKeesport Hospital in McKeesport, Pa. . . . Dr. Ronald Miller recently entered the private practice of orthopedic surgery in Council Bluffs. He is a native of Clarinda. . . . Dr. Alfonzo F. Magat, Jr., former head of surgical resident teaching at Des Moines' VA hospital, has joined Drs. Ramon A. Yaldua and Christina Crespo-Yaldua in Forest City.

Dr. Senen Dalisay has joined the Keokuk Medical Clinic. Dr. Dalisay received the M.D. degree at University of St. Thomas in the Philippines. He interned at Ohio Valley Hospital in Steubenville, Ohio, and had a surgical residency at Coney Island Hospital in Brooklyn, New York and Charleston General Hospital, Charleston, West Virginia. He has practiced two years in the Philippines. . . . Dr. Tia S. Byun, an obstetrician and gynecologist, has joined the Gilfillan Clinic in Bloomfield. Dr. Byun received the M.D. degree in Korea. His U. S. training includes residencies at the Fordham and Montefiore Hospitals in Bronx, New York; and Jamaica Hospital, Long Island, New York. Dr. Byun has been associated with the Highland Clinic in Williamson, West Virginia. . . . Dr. Donovan F. Ward, Dubuque, spoke on "Counseling the Sick and the Bedfast" at an IMPACT Workshop at University of Dubuque. . . . Dr. Ada Perel Gaskill has closed her Des Moines office to become Chief of Medical Services at the Green River Comprehensive Care Center in Owensboro, Kentucky.

**Dr. Homer E. Wichern,** Des Moines, has been named regional delegate to the House of Delegates of American Hospital Association. He is also on the National Advisory Board for the Social Security Disability Program.

Dr. Robert Richardson, director of intensive care unit at University Hospitals, spoke at a recent meeting of Wapello County Medical Society, Dr. Richardson discussed "Acute Respiratory Failure." . . . Dr. Frederic M. Ashler, Hamburg, is new president of Iowa Academy of Family Physicians. Other new officers are—Dr. James Coddington, Humboldt, president-elect; Dr. D. J. Ottilie, Oelwein, vice president; Dr. George A. Kern, Des Moines, secretary-treasurer; Dr. Marvin Moles, Newton, board member; Dr. Gene Michel, Cherokee, board member; Dr. William Castles, Dallas Center, delegate to American Academy of Family Physicians and Dr. Raymond Frech, Newton, alternate delegate. . . . Dr. Raymond Schamel has joined the Radiology Department at Trinity Regional Hospital in Fort Dodge. Dr. Schamel received the M.D. degree at University of Colorado. Following three years' Navy service, he completed his residency in radiology at St. Luke's Hospital in Denver. . . . Dr. James R. Mincks, Bloomfield, recently received the Davis County Farm Bureau's outstanding citizen award. Dr. Mincks is past president of Bloomfield Lions Club and an active member of Bloomfield United Methodist Church. He helped organize the local American Field Service Chapter and served as its first president. In 1967, he served two months aboard the S. S. Hope in Colombia. Dr. Mincks and his family have hosted several foreign students.

Dr. Walter Kopsa, Tipton, was presented an award at 6th annual meeting of Hoover Health Council. Dr. Kopsa was honored for helping to found the health council. . . . Dr. Curtis C. Fredrickson has joined the Poweshiek County Mental Health Center in Grinnell. A U. of I. medical graduate, Dr. Fredrickson interned at Sioux Valley Hospital in Sioux Falls, South Dakota and had a psychiatric residency at the U. of I. . . . Dr. Richard Lawton, U. of I. professor of surgery, was guest speaker at a forum on kidney disease in Sioux City. Dr. George Spellman, director of the dialysis unit at St. Vincent Hospital in Sioux City, also participated in the program. . . . Dr. B. R. Withers, Waukon, has been reappointed president of board of directors of Allamakee Community school district. ... Dr. James C. Carr, New Hampton, has been named one of the Outstanding Young Men of America for 1974. His name will appear in the annual biographical compilation sponsored by



leading men's civic, service and professional organizations. Dr. Carr was cited for outstanding civic and professional service to his community.

**Dr. Richard L. Vaught,** Sioux City, has been elected to the Society for Pediatric Urology. Dr. Vaught is a Diplomate, American Board of Urology, and Fellow, American Board of Pediatrics, Section on Urology.

Officers of the Iowa Clinical Surgical Society are Dr. John T. Bakody, Des Moines, president and Dr. Campbell F. Watts, Cedar Rapids, president-elect.... Dr. L. C. O'Toole, LeMars, is honorary chairman for Westmar College's "Western Iowa for Westmar" fund drive. ... Dr. Kenneth R. Friday, Jefferson, won the Appaloosa Grand Performance Championship for the second straight year at 1974 Iowa State Fair. Dr. Friday placed first in Camas Prairie stump race, second in Nez Perce stake race and fourth in trail class. ... Dr. M. Lee McClenahan, Sigourney, has opened an additional office in What Cheer. . . Dr. Donner Dewdney has been named supervisor of

clinical services and medical director of Orchard Place in Des Moines. Dr. Dewdney received the M.D. degree at University of Western Ontario in London, Canada. His residency in psychiatry was at State Hospital in Topeka, Kansas. He was on the faculty of Menninger School of Psychiatry and served as chief of the pre-adolescent unit of Topeka State Hospital.

Dr. Dale Harding, Eagle Grove, was guest speaker at a recent meeting of local Hypoglycemia Club. . . . Dr. E. B. Wilcox, Oskaloosa, was honored recently by the community's Kiwanis Club for many years of service to local citizens. Dr. Wilcox has just reached age 97 and is a charter member of Oskaloosa Kiwanis. He was president in 1950, and Lieutenant Governor of Iowa-Nebraska District in 1951. A life member of the Iowa Medical Society, Dr. Wilcox received the M.D. degree from the University of Kentucky in 1905. He began his practice in Oskaloosa in 1908. . . . Dr. John T. Howell began a family practice in Webster City in October. A 1970 grad-

# IOWA MEDICAL MISCELLANY

(Continued from page 457)

to devise continuing education requirements through rules and regulations; (2) create a new legislative committee to review activities in the total area; and (3) make optional the annual renewal of licenses by the licensing boards.

OCHP STUDY . . . The "State Comprehensive Health Plan for Iowa" is undergoing further revision by the Office of Comprehensive Health Planning. The additional modification has been requested by HEW. Definition of terms "primary care," "secondary care," and "tertiary care" are involved in terms of facilities, equipment and manpower.

KIDNEY FOUNDATION... The Kidney Foundation of Iowa is accepting applications for its competitive research fellowships. Emphasis is on laboratory and clinical research in nephrology. Fellowships are for \$10,000. Application deadline is 12/1/74. Contact Kidney Foundation of Iowa, 3615 Douglas Avenue, Des Moines, Iowa 50310.

BOOK COLLECTION . . . John Martin, M.D., Clarinda, has donated his collection of rare medical books to the new Health Science Library at the University of Iowa. Dr. Martin's books, nearly 800 in number, include some which date back to the 15th century.

INSTALLED... John C. MacQueen, M.D., Iowa City, was installed October 22 as 45th president of the American Academy of Pediatrics. Dr. MacQueen is professor of pediatrics at the U. of I.

HMO INTEREST . . . It appears likely experimentation with a Health Maintenance Organization will begin in 1975 in the Bloomfield area with the Gilfillan Clinic providing medical leadership.

PHYSICIAN INCREASE . . . The number of physicians, including resident doctors, increased in Iowa by 60—from the 1973 total of 2,995 to 3,055 in 1974, according to figures reported by the University of Iowa College of Medicine. Family practice interest continues to grow—32 freshman medical students were interested in 1967; 85 were in 1973.

uate of University of Arkansas School of Medicine, Dr. Howell interned at Tripler Army Medical Center in Honolulu. . . . Dr. Robert Soll, Waterloo, was guest speaker at September meeting of Black Hawk Chapter of American Association of Medical Assistants. He discussed multiple sclerosis. . . . Dr. J. B. Roberts, Ottumwa, has been appointed by Wapello County Medical Society to serve as director of county immunization clinic.

# **DEATHS**

Dr. Oscar Alden, 65, Red Oak, died September 10 at Murphy Memorial Hospital. A 1934 graduate of Creighton University Medical College, Dr. Alden interned at St. Catharine's Hospital in Omaha and entered medical practice in Red Oak in 1936. He had been a member of Red Oak Fire Department since 1950 and served as Department Physician and Public Relations Officer. Dr. Alden was a member of Iowa Fireman's Association and Montgomery County Board of Health; served as Montgomery County Medical Examiner; was a past vice-president of Iowa Medical Society and a former member of IMS Judicial Council; was past president of Red Oak Chamber of Commerce and charter member of Red Oak Lions Club. Montgomery County Isaak Walton League and American Medical Association.

Dr. K. W. Woodhouse, 64, former Cedar Rapids physician and surgeon, died September 18 at his home in Englewood, Florida. A graduate of U. of I. College of Medicine, Dr. Woodhouse located in Cedar Rapids following completion of his residency in surgery in Philadelphia, Pa. During World War II, he was in charge of overseas hospitals and received the Bronze Star, Legion of Merit, and the French Croix de Guerre for his service during Normandy invasion. Dr. Woodhouse was a past president of St. Luke's medical staff; past president of Linn County Medical Society; member of Iowa Medical Society and American Medical Association.

Dr. I. C. Jerdee, 87, Clermont, died September 17 at the Community Memorial Hospital in Postville. Dr. Jerdee received the M.D. degree at Chicago College of Medicine and was a family practitioner in Clermont for 50 years. He was a life member of Iowa Medical Society and American Medical Association.

# Can you afford to miss a \$7,500 tax deduction?

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IMMEDIATE OPENING for Ob-Gyn and Internal Medicine, specialties to establish successful practice with 14-man multispecialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

VACANCY—ADMITTING, PRIMARY CARE, PERSONNEL PHY-SICIAN. Desire physician interested in academic university affiliation, preferably board certified in family practice. Five day week, nights free. VA benefits and retirement. Salary \$26,000 to \$32,000 depending on qualifications. Nondiscrimination in employment. Inquire: Chief of Ambulatory Care, VA Hospital, Iowa City, Iowa 52240. Phone 319/338-0581.

WANTED—FAMILY PHYSICIAN to associate with four-man clinic. Accredited hospital, full surgical and radiological coverage. Contact Paul Vander Kooi, M.D., Orange City, Iowa 51041. Call 712/737-4938 office or 712/737-4104 home.

TRAUMA CENTER/EMERGENCY ROOM COVERAGE—Mercy Hospital, Cedar Rapids, Iowa. Modern, well-equipped hospital, guaranteed minimum income of \$36,000, 42 hours per week. Excellent staff specialists on call for specialized needs. Progressive city 25 miles from University of Iowa Medical School. Good recreational facilities, excellent school system. Contact Bernard M. Grahek, Mercy Hospital, 701 Tenth Street, S.E., Cedar Rapids, Iowa 52403. Phone 319/398-6133.

PHYSICIAN, CHIEF OF MATERNAL AND CHILD HEALTH SERVICES—To assume responsibility for the maintenance and supervision of the Maternal and Child Health Program for a City-County Health Department now serving a population of approximately 400,000. Physician, licensed or eligible to practice medicine in Nebraska, Master of Public Health or Board eligible in arcas of Preventive Medicine or Pediatrics or equivalent graduate or resident training, Salary range \$29,100 to \$37,090, plus retirement and other fringe benefits. Contact Health Director, City-County Health Department, 3939 Leavenworth, Omaha, Nebraska 68105. Telephone 402/444-7471.

INDUSTRIAL PHYSICIAN NEEDED to operate an office of occupational health for Ames Laboratory, U. S. Atomic Energy Commission located on the campus of Iowa State University, Ames, Iowa. Desire a generalist or physician intercsted in an occupational health program for 500 employees. Program involves physical examinations, sick call and diagnosis and treatment of occupationally related health problems. 40-hour week, I month vacation time for meetings and other University fringe benefits. Please call L. N. Spohnheimer, M.D., 515/294-2056 or write C. S. Robert, Personnel Office, Ames Laboratory, Iowa State University, Ames, Iowa 50010 An equal opportunity employer.

FOR SALE—100 M.A. GE X-ray; Bucky, fluoro., and all accessories. Write or call Robert Dolan, M.D., 101 College Drive, Decorah, Iowa 52101. 319/382-3133.

WANTED—MEDICAL DIRECTOR—Family practitioner to serve in health clinic. No Sunday or holiday work. Basic 40-hour week. Salary, \$36.000 a year. If interested, please contact Clinic Manager, Evelyn Davis Health Clinic, 1154 5th Avenue, Des Moines, Iowa 50314. Phone 515/283-2571.

CLINIC PHYSICIAN—With special interest in the area of Maternal and Child Health for a City-County Health Department now serving a population of approximately 400,000. Physician licensed or eligible to practice medicine in Nebraska. Contact Health Director, City-County Health Department, 3939 Leavenworth, Omaha, Nebraska 68105. Telephone 402/444-7471.

WANTED—FAMILY PRACTITIONER to join 8-man multispecialty group. Excellent clinic and hospital facilities. Unusually progressive small community in which to live and raise a family. Excellent salary and benefits, partnership in twelve months, liberal vacation and meeting time, Contact Richard A. Callis, Administrator, McCrary-Rost Clinic, Lake City, Iowa 51449. Telephone 712/464-3194.

GENERAL PRACTITIONER—Geriatric interest—Psychiatric Hospital. Liberal fringe benefits. Near recreation areas and State Capital. Beginning salary \$27.287 to \$31,806 depending on qualifications. Internship. U. S. citizen and licensure required. Equal opportunity employer Contact Louis Jensen, M.D., VA Hospital, Knoxville, Iowa 50138.

FOR SALE—Used exam table, treatment cabinet, waste receiver cabinet, and operator stool to match; steel desks, chairs,  $8\times 5$  card files; water bath, sterilizers, SANBORN E.K.G., Kinemometer, refrigerators with stainless steel inserts, baby scale, dictaphone. Contact H. R. Wold, M.D., 613 N. Wash., Madison, S. Dakota, 57042. 605/256-4519.

NEEDED—STUDENT HEALTH PHYSICIAN—Salary negotiable, 40 hour week, month vacation, continuing education. An equal opportunity employer. Contact Harley G. Feldick, M.D., Student Health Service, University of Iowa, Iowa City, Iowa 52242.

WANTED—GP/FAMILY PRACTITIONER in Council Bluffs, Iowa. Salary \$50,000. After 2 years, if agreed by both parties, full partnership. Gross in 1973, \$150,000. Desire sabbatical for 2 years. Write or call J. V. G. Angel, M.D., 1705 McPherson, Council Bluffs, Iowa 51501. Call 712/328-2231, office or 712/323-1443, residence.

BUSY THREE-MAN FAMILY PRACTICE PARTNERSHIP in Marshalltown, Iowa (pop. 30,000) needs replacement for one partner leaving for a residency. Salary first year and then full partnership. Hospital facilities across the street. 200-bed well equipped hospital. Contact E. L. Jacobs, M.D., Marshalltown, Iowa 50158 for further details. Phone 515/752-3449.

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# respond to one

According to her major mptoms, she is a psychoneuitic patient with severe ixiety. But according to the escription she gives of her elings, part of the problem ay sound like depression. his is because her problem, though primarily one of exssive anxiety, is often accominied by depressive symptomology. Valium (diazepam) in provide relief for both—as e excessive anxiety is reved, the depressive sympms associated with it are also ten relieved.

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two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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For further information on this subject, the following references are provided:

1. Henry BW, et al: Dis Nerv Syst 30:675-679, Oct 1969.

2. Hollister LE, et al: Arch Gen Psychiatry 24:273-278, Mar 1971. 3. Claghorn J: Psychosomatics 11:438-441, Sept-Oct 1970.



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in psychoneurotic anxiety states with associated depressive symptoms

rveillance because of their predisposinto habituation and dependence. In agnancy, lactation or women of childaring age, weigh potential benefit ainst possible hazard.

ecautions: If combined with other psyotropics or anticonvulsants, consider refully pharmacology of agents emyed; drugs such as phenothiazines, rcotics, barbiturates, MAO inhibitors d other antidepressants may potentiate action. Usual precautions indicated in tients severely depressed, or with latent pression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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# President's Page

Two years ago, or more, the media was busy informing people of the "health care crisis." We were told of our "non system" of "cottage medicine," about how poorly it was delivering health care.

Former President Nixon, some legislators, and other government officials declared a need for reform. This, of course, mandated government action. Such action would involve management of health care by economists, social workers and government employees. Little emphasis was or has been placed on the cost of such reform in manpower or dollars. When costs (and manpower) are mentioned by the reformers, the figures are unrealistic, as they were 10 years ago when Medicare and Medicaid were evolved.



Several months ago, I wrote the Secretary of HEW to ask for dollar and percentage figures for the "administration" of Medicare and Medicaid. I presumed these figures to be readily available since the government was and is contemplating a national health insurance program involving the entire population. No answer has ever been received to my letter.

Recently, many space-and time-consuming items have been in the press, e.g., Watergate, impeachment, pardon, energy crisis, inflation, etc. I predict now the health care crisis will return to the headlines and articles in preparation for enactment of NHI.

We must familiarize ourselves with the details of the various proposals. We must pursue aggressively the right to continue to give the people of Iowa the excellent care they deserve in spite of new federal laws and regulations.

Merry Christmas to All and a Happy New Year!

Sincerely,

Ralph L. Wicks

Ralph L. Wicks, President

# IOWA Medical Miscellany

OVERHEAD SAVINGS... A Workmen's Compensation Insurance Savings Plan has been approved by the IMS Executive Council and is being made available to Iowa physicians by the Dodson Insurance Group of Kansas City, Mo. Information about the Savings Plan is being distributed.

PSRO POLL... Response to recent IMS PSRO poll was excellent. Informal poll prompted 1,100 responses with nearly 95% favoring the Iowa Foundation for Medical Care as Iowa PSRO.

RED OAK NAMED . . . A model regional primary health care center is to be located in Red Oak. Ten sites were considered for the southwest Iowa project which is to be funded (for planning and development) by a \$52,800 grant to the U. of I. College of Medicine. The College will assist in planning and developing the program to be directed by local physicians. Drs. Harold Bastron and Jack Fickel will be nucleus of center's initial professional staff. Clinic construction is to begin in 1975. U. of I. family practice residents and medical students will utilize the Red Oak center.

HYPERTENSION SCREENING . . . Hypertension screening activities in Iowa were reviewed at recent meeting organized by the State Department of Health. Benefits and expansion of programming in this area were considered. IMS was represented.

CONFER WITH DENTISTS . . . IMS Board of Trustees conferred recently with officers of the Iowa Dental Association on legislative and other matters of mutual interest.

IMMUNIZATION... Thirty-two county medical societies have designated an immunization chairman in response to request from State Department of Health and IMS Committee on Maternal and Child Health.

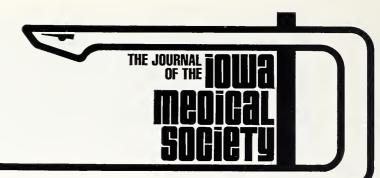
'75 IMS HOUSE... Financial woes have hit Hilton Inn, under construction in Des Moines, to force change in schedule for 1975 IMS House of Delegates. New schedule has House meeting April 30/May 1 at the Hyatt House.

**RX STUDY...** Committee on Drug Abuse is in early stage of a study to involve computer analysis of 30,000 prescriptions. Overall study is a project of U. of I. College of Pharmacy with data supplied by pharmacists and physicians in 100 Iowa communities.

ASSEMBLY COVERAGE . . . IMS coverage of the 1975 Iowa General Assembly will take a new form. James West, a highly-respected attorney and active lobbyist, will represent the Society on the hill. Rick Phillips, who has covered two sessions for the IMS, has accepted a new position. R. B. Throckmorton continues as the Society's general legal counsel.

3.7 MILLION... Muscatine industrialist Roy J. Carver has given \$3.7 million to The University of Iowa Foundation for use in several health care areas. Of this, \$2 million will support construction of a major addition to University Hospitals and Clinics. The addition will include a trauma and emergency treatment center, clinical orthopaedic facilities and a family practice clinic. Another \$1.5 million will establish and endow the Roy J. Carver Professorship of Internal Medicine. James A. Clifton, M.D., professor and head of the department, will be the first recipient.

ON GUARD . . . A billing-type statement for a \$185 listing in the "International Medical Directory of Physicians" from "Mayo Research and Publishing Co." was sent to all U. S. physicians in late October. To thwart this swindle, a fraud order has been issued by the U. S. Post Office which will stop and return all mail addressed to the Hong Kong address which appears on the statement.



VOL. 64 No. 12 DECEMBER, 1974

TABLE OF CONTENTS		In the Public Interest 499
What Every Physician Should Know About Keogh	500	The Question Box
The Physician's Assistant as a Buffer in the Delivery of Primary Care		State Department of Health 504
Herman A. Hein, M.D.	507	Educationally Speaking 514
Bowel Damage After Radiation Therapy of Carcinoma of the Cervix John J. Ptacek, M.D.	510	Medical Assistants
John J. Flacek, W.D.		About Iowa Physicians 518
EDITORIALS		Deaths
Christmas Lights	513	Index to Volume LXIV
SPECIAL DEPARTMENTS		
President's Page	496	MISCELLANEOUS
Iowa Medical Miscellany	497	Feeling Good and a second of 509

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# MEDICAL LIABILITY—A TOP PHYSICIAN CONCERN

WHAT IS THE MOST pressing issue before the medical profession today?

Answers to this question vary, obviously. But odds are that medical liability will rank at or near the top of any physician list.

Many unknowns surround the complex subject of medical malpractice. However, there are three pressing knowns: (1) the number and costs of malpractice claims and suits are increasing; (2) malpractice insurance premiums are rising and coverage is becoming increasingly difficult to secure; and (3) physicians generally feel threatened by the current legal climate in which claims and suits are being filed (to the extent of practicing defensive and more costly medicine).

A great many people, many of them quite expert, have been and are ruminating on this matter. Even so, a consensus has not been forthcoming on what should be done. The inability to find firm answers is due in part to the scarcity of hard, quantitative data. And, too, the problem is seen in different light depending on your vantage point, e.g., physician, plaintiff's attorney, insurance representative.

How grave is the situation? The whole issue is so complex these comments here are scarcely the tip of the iceberg.

Multi-million dollar verdicts have been handed down in California at a rate of one a month for the past year or more. In New York, where medical liability premiums are among the highest in the nation, physicians in the state-sponsored program have experienced 93.5% rate increases this year. In Texas, a major carrier left 300 physicians with no coverage. In Michigan, two major insurance companies will no longer cover high-risk physicians.

What are the reasons for these developments? Our population has become increasingly litigation conscious, for any number of reasons. The Insurance Services Office, an independent rating organization, reports only 1.7 physicians in 100 were

sued by patients in 1966. In 1972 the figure was set at three of 100.

There's been a hike in awards as well. In 1970, the average award, either as a settlement or a court judgment, was just under \$5,000. In 1973, the average was about \$8,000.

Correspondingly, premium rates for medical liability have jumped dramatically. Surgeons have had a 950% rate increase in 10 years since 1960. For other physicians, rates increased 540% in that time.

The situation in Iowa has been less acute than in other parts of the nation. But indications of late suggest the time is not far off when the dilemmas of the east and west will come to bear on Iowa.

How has the Iowa Medical Society involved itself in this problem (1) in behalf of its member physicians, and (2) in behalf of the public whose doctor bills must be increased to cover this mounting overhead item (for each million-dollar-plus verdict it is suggested that every physician in the country must pay another \$5 to \$10 in premium)?

The Society's Medico-Legal Committee has been assigned responsibility for keeping tabs on the situation in Iowa. It has been challenged to guide Iowa physicians through the complex medical liability maze. Efforts have been broad and active, if not overly dramatic and fruitful. For example, the Committee has:

- Conducted two surveys of Iowa physicians to ascertain the state medical liability situation. (Ninety percent of the respondents to one survey reported no claims activity between 1965 and 1970. However, respondents reporting suits reflected an upward trend over the five-year period.)
- Completed a survey of state medical associations to determine how extensively counterpart organizations are involved in programs formally tied with an insurance company. More than half do have some type of affiliation.

(Please turn to page 501)

# IN THE PUBLIC INTEREST

# What Every Iowa Physician Should Know About Keogh

THE EMPLOYEE RETIREMENT INCOME SECURITY ACT of 1974 was signed into law by President Ford on Labor Day. It liberalized the regulations on retirement plans for self employed individuals (sole proprietors or partnerships) and their employees. These plans are often referred to as Keogh or HR-10 plans.

The most significant change was the substantial liberalization in the area of contributions or payments to a plan. Formerly, annual payments were limited to the lesser of 10% of earned income or \$2500. Under the new law, the limits are the lesser of 15% of earned income or \$7500. These changes were effective January 1, 1974 and are available for 1974 payments if the plan document executed previously has been amended to provide for the higher limits. Many insurance companies, banks, mutual funds and other plan sponsors will be contacting employers yet this year to complete the necessary amendments in time for 1974 payments. In line with the increased limits, no greater than \$100,000 of earned income can be used in determining annual payments. Other changes incorporate a 6% penalty tax for years in which excess contributions are maintained in a plan (effective January 1, 1976) and a 10% penalty tax on premature distributions (also effective January 1, 1976).

Although the IRS will allow deductions for increased payments on 1974 returns, the Iowa state income tax regulations have not been altered by the Iowa General Assembly. As a result, the maximum Iowa deduction for 1974 is still limited to 10% of earned income or \$2500. The next session will likely see legislation to bring the Iowa limits in line with the federal limits.

There has been no change in the requirement that all full time employees with three years of employment must be included in a plan (although employees with less than three years may be included, provided all employees are treated the same). However, the new test for full time emThis summary has been provided by the Society's insurance administrator, The Prouty Company of Des Moines. Prouty Company representatives are available to present informational programs on Keogh and other insurance/investment opportunities at county medical society meetings. Please contact IMS Headquarters if a program or other information is desired.

ployment is whether or not the employee works 1,000 hours or more per year. There was no change in the requirement for immediate vesting of values.

There also has been a liberalization in the timing of payments for a particular tax year. For tax years beginning after the date of the new law (September 2, 1974), it appears that regulations will allow payments to be made after the tax year ends but prior to the time the tax return is filed. For example, if a tax year ends December 31, 1975 a payment made prior to April 15, 1976, or the date the return is filed, if earlier, for the 1975 tax year is deductible on the 1975 return.

Voluntary payments to an HR-10 plan may still be made by an owner-employee (although no tax deduction may be taken for these amounts) if there are common-law employees actually participating in the plan. These maximum amounts remain at the lesser of 10% of earned income or \$2500, although now plans may allow all or a part of voluntary payments to be withdrawn without penalty. Although not tax deductible, earnings on voluntary payments accumulate on a tax deferred basis in the same manner as regular plan payments.

A brief review of some of the continuing aspects of HR-10 regulations may be helpful to round out knowledge on the subject. Although a partnership may establish a plan, only those partners who wish to participate need do so. How-

ever, a plan cannot exclude common-law employees who are otherwise eligible. It is not possible to distribute assets of a plan to owner-employees without penalty prior to retirement or age 59½ for reasons other than disability, and owner-employees must start receiving income from the plan prior to age 70½. Life insurance may be part of a plan, providing it is incidental to the plan and not more than 50% of the annual payment goes to

### IN THE PUBLIC INTEREST

(Continued from page 499)

- Reviewed proposals from several insurance companies interested in offering group-type coverage to Iowa physicians. Additional, and somewhat unique proposals, are now before the Committee in a preliminary status.
- Maintained communication with various companies providing coverage to Iowa physicians to resolve problems and to attempt to assure their continuing presence in the state.
- Discussed medical liability matters periodically with the State Insurance Commissioner and his representatives.
- Initiated deliberations with the Iowa State Bar Association to determine how the legal and

pay the life premium.

HR-10 plans continue to be an attractive method for the unincorporated medical practice to provide for retirement accumulations on a tax deferred basis for a doctor and his employees. The applicability in any specific situation needs to be considered on the basis of all facts involved, and anyone establishing a plan should seek the advice of his accountant, attorney or other tax counsel.

medical professions might work together to alleviate existing and approaching problems.

Up to now, the Iowa Medical Society has encouraged competition for the professional liability insurance business of its member physicians. Now, coverage has become much less accessible, costs have skyrocketed, and the forecast is bleak. This could herald a change.

The Medico-Legal Committee is scheduled to meet December 18 to assess the situation and chart a future course.

As the federal Commission on Medical Malpractice reported in 1973, "We are not dealing with a matter of concern only to the relatively few aggrieved patients and the doctors and hospitals they sue. We are dealing with a problem of national concern that vitally affects the ways in which health care is rendered in this country."





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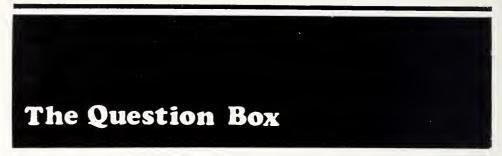
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by MARVIN H. DUBANSKY, M.D.

Dr. Dubansky hands the Polk County president's gavel to D. J. Walter, M.D., in January.

# How would you characterize your year as president of the Polk County Medical Society?

It has been busy. It is difficult in a busy practice to also carry on the many activities and functions required in a county society as large as Polk County. The numerous routine activities on the medical side of the Society have been supplemented by considerable activity in the health planning area. The actions of a local assembly and an areawide assembly both affect medical practice in Des Moines. No one individual can stay on top of this. Fortunately, we've had some men who have been quite energetic and interested who have been working hard in this regard. The question of PSRO, and the Iowa Foundation versus the Union's approach to the PSRO, have been of ongoing interest. Frankly, in reviewing my year as president, I don't know if I have actually accomplished anything, but if nothing else, one of my prime aims was to try to involve the entire membership in the activities of the Society. I'm certain we've not involved everyone but I'm also certain we have stirred up a few people and have gotten them much more active. This kind of effort has to be continued.

# What priority concerns does the state's largest county medical society have?

Our principal concern is the impact of the upcoming PSRO and in what mode it will be handled. Another main concern is over the activity of the Health Planning Council in this area. It has taken aim at the very basic way in which we are practicing today. If all of its recommendations are carried out, I feel it will lead to the elimination of the private practitioner and put the hospitals in control of the practice situation in this community. There may be considerable argument over

this but one does not have to do much reading between the lines to see that powerful forces are at work and we must be powerful to combat this activity.

# Is the status of medical care in Polk County—manpower, facilities, etc.—better or worse than say 10 or 15 years ago?

Our manpower has increased very slightly, going up perhaps 10-15% over the last 10 years. Most of this has been in specialization with the loss of more and more family practitioners. Our community, without question, needs more family practitioners and specialists in certain areas. Our three major hospitals in Des Moines have all improved their patient care facilities and and their basic underlying laboratory and radiographic facilities within the last two or three years. The medical facilities themselves are greatly expanded and improved.

# How do you view the professional future for today's medical students?

Despite attacks from almost all sides, the future of the medical profession is bright. Medical care, without question, is at the highest level it has ever been. The opening of the door with just a peek toward immunology and chemotherapy in the field of malignancy is truly exciting. I may be prejudiced but I think there are more changes taking place in the actual care of patients at this time than ever before. This is an exciting time to be coming into practice, and I believe it will be more exciting in the future. There will be uncertainty and conflict with respect to national health insurance, HMO's, PSRO and health planning. I believe students should become involved not only in patient care, but it is mandatory that they know what is happening in the socio-economic realm.

### Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information, Here. too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

# **Training of Sales Representatives**

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce — information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

# Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

## The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

### The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

## Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association 1155 Fifteenth Street, N.W. Washington, D.C. 20005



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# State Department of Health

# TETANUS AND ITS TOXOID

Two cases of tetanus, one with an ultimately fatal outcome, have been reported to the Iowa State Department of Health in recent weeks. This disease has become extremely rare in Iowa, with these being the first cases reported since 1972. The widespread use of tetanus toxoid among military personnel during World War II and routine childhood immunization since that time have almost eliminated the disease. Although the disease is seldom seen, questions relating to the proper use of the toxoid and the frequency of booster doses reach the Department with some regularity. The Division of Health of the State of Florida has recently published a very complete and concise discussion of tetanus toxoid prophylaxis which should help in answering such questions. This essay is reprinted below with permission from Florida's Bureau of Preventable Diseases:

# TETANUS TOXOID PROPHYLAXIS

The 1974 American Academy of Pediatrics Report of the Committee of Infectious Diseases (the Red Book), recommends that routine boosters for tetanus prophylaxis be given at 10-year intervals following the primary series. It is further advised that "for clean, minor wounds, no booster dose is needed by a fully immunized child unless more than 10 years have elapsed since the last dose. For contaminated wounds, a booster dose should be given if more than 5 years have elapsed since the last dose. . . . In wound management, therefore, it is unnecessary to give booster injections more than every 5 years."

The 10-year interval booster recommendation is not new, having been made by the American Public Health Association in 1965, and by both the Public Health Service Advisory Committee on Immunization Practices and the American Academy of Pediatrics Committee on the Control of Infectious Diseases in 1966. Neither is the advoca-

tion of 5-year interval injury prophylaxis a new departure. The Public Health Service Advisory Committee on Immunization Practices originally made this recommendation in 1972.

These dictums have a solid basis in the scientific literature. Since tetanus toxoid became universally available during World War II, successive studies have been performed to determine the duration of immunity following a primary series of immunization and to assess the rapidity of antibody recall following booster inoculations given at extended time intervals after the primary series. As experience has increased over the past three decades, the following has become apparent.

- 1. The threshold level for protective toxin antibodies is probably between 0.01-0.1 antitoxin units (AU) per milliliter. Most authors now concede that the lower limit is acceptable.
- 2. Protective levels of antibodies persist for many years in the fully immunized. Indeed, in one study 87.5% (91/104) of people studied had levels of 0.01 AU/ml or greater after 15 years had elapsed since their last dose of toxoid.¹ Another more recent study states with 99.9% confidence that protective levels of antibodies persist at least 12 years and probably much longer in immunized individuals.² Although antibody levels at 5 years after the primary series have not been well studied, it is inconceivable that they would be lower than levels at 12 and 15 years, and most certainly would be higher.
- 3. Many investigators have demonstrated that the elapsed time interval since the last toxoid inoculation in the fully immunized has a bearing on the booster amnestic response; the shorter the interval the more rapid the rise in antibody titer. However, all have shown that regardless of the length of the intervening time span (with up to 20-year intervals studied) recall to protective antibody levels occurs. If greater than 10 years has

(Please turn to page 512)

# The Physician's Assistant as a Buffer In the Delivery of Primary Care

HERMAN A. HEIN, M.D. lowa City

Many articles have appeared recently on the use of physician's assistants. 1-5 Several authors have cited the acceptance of these physician extenders by the general public.1, 4, 6-8 Training programs for the physician's assistant (PA) have become solidified over the past several years,9 and certification is now possible through several qualifying examinations. Thus, a cloak of respectability has settled on the PA. However, considerable controversy continues among both physicians and PAs as to the ultimate role of the PA in the American health care system, especially in the area of primary care.4 Recent concern has centered on the following questions: "Will PAs replace family physicians?" "Is the PA a good investment in terms of cost versus vield?" "Can the PA be relied upon when operating in an independent fashion, i.e., not under direct supervision?" This discussion will consider these issues and will be based on practical The role of physician's assistants in a model primary care setting in Muscatine, lowa is presented. Basic ideas relating to the preparation of the PA for primary care are discussed. The use of the PA as a "buffer" for the primary care physician is suggested. The author feels appropriate use of the PA may actually improve the quality of care by allowing the physician sufficient time for complex problems and for keeping abreast of current medical knowledge.

experience gathered at a model primary care setting.

For the past nine months the author has worked with physician's assistants (5) and family physicians (3) in a rural model health care center (Muscatine Community Health Center—Muscatine, Iowa). The basic model consists of 3 family practice teams. Each team has a family physician at the helm with one or two PAs assigned to each team. The Center also employs nursing personnel, largely licensed practical nurses, with registered nurses in supervisory capacities. The teams are complemented by a pediatrician (the author) and an internist, who work with the family physicians and do not maintain individual practices. Working in this fashion, the family physician is involved in the patient's con-

Dr. Hein is an assistant professor in the Department of Pediatrics at the University of Iowa College of Medicine and is associated with the Muscatine Community Health Center, Muscatine, Iowa.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF DECEMBER, 1974.

tinuing care regardless of the severity of the illness.

The program physicians feel this model has become successful with the addition of the PA. All of our PAs have graduated from accredited training programs (3 from Duke, 1 from Alabama, and 1 from Oklahoma). They have successfully passed the National Board of Medical Examiners' certifying examination for physician's assistants. At the outset, the medical staff regarded the PAs as not ready to accept patient responsibility directly or, in other words, to operate in an independent fashion. They were basically welltrained in the rudiments of physical examination, but lacked sufficient insight into disease processes. This made them susceptible to oversight, or perhaps, over diagnosis. For this reason, during the initial 6 months, the PAs spent periods of time (4 to 6 weeks) with each physician, and in this "training period" became familiar with the physician and his method of practice. During this period a special pediatric training team was established under the supervision of the pediatrician to give a concentrated exposure to child care. The medical staff believe a similar training period would be valuable for any physician's assistant entering a primary care setting.

### WORK CLOSELY

We now have confidence in the PAs' ability to handle a variety of patient complaints. Even so, we continue to work closely with them to insure a high standard of patient care. After-hours calls are handled on a first call basis by the PAs. A complete log of calls (including advice given to the patient) is maintained and regularly reviewed. When matters of uncertainty arise the physician on call is consulted. The family physicians working with the PAs now regard being on call as much less of a burden. More time is now available to the family physicians to further their education, to participate in community medical activities, and to enjoy their families. The PAs believe the tasks they have been delegated are reasonable; they are functioning in a fashion commensurate with their training and experience.

Against this background the matter of how the PA can be used as a buffer in the delivery of primary care can be discussed.

One of the major concerns is that the PA will replace the family physician. We doubt the PA will ever supplant the family physician; however, we believe the physician's assistant will contribute significantly to better medical care working with family doctors. It is our contention that many physicians, although well rewarded financially, find practice frustrating because of an inability to maintain the quality of care they were initially capable of providing. There is insufficient time for the average physician to devote himself to the problems that truly require his talents. He is bogged down by the trivial complaints that now demand more and more of his time. This is not to imply the so-called trivial patient complaints should go unanswered. The point is, these complaints can be answered very adequately by someone with less training than the physician.

### IATROGENIC FRUSTRATION

It is unfair to lay all of the blame for the physician's frustration on the public. A fair share of the frustration is iatrogenic. If we can agree that physicians in this country are well-trained at the outset, how then do we explain the feelings of inadequacy that most physicians express after being in practice for some years? My impression is that for years, physicians, particularly those in the rural primary care settings, have tried to be "all things to all people." The image that has been projected is that of an iron man who, although he has been up most of the night, is capable of seeing a full schedule of patients the following day. It seems to me that no human being is so physically or emotionally resistant to this sort of stress that he will be able to, first of all, enjoy what he is doing, much less be able to pursue educational activities that contribute to his ability to maintain a high quality of care. The average physician is motivated to such a degree that given the opportunity, he will maintain a high degree of proficiency. Our group believes the greatest value of the PA to the practicing physician comes from his ability to handle telephone calls, especially after hours, take the great majority of after-hours patient visits (and in return for performing these duties, the daytime duties of the PA should be appreciably lightened and sufficient free time granted) and help with the routine aspects of a physician's office practice.

In this fashion the PA serves as a buffer for the physician, separating him from some of those aspects of primary care that, perhaps, previously have served as a source of frustration. It goes without saying that if a PA is going to serve the patient well, it is necessary for him to work close-

ly with the physician. If we simply interpose another lesser trained person in the health care scheme, we are not appreciably altering the matter of quality of care. However, if the person interposed truly reflects the ideals of a caring and skillful physician, then the quality of care does not suffer, and indeed, the overall quality may improve.

In fairness to the PAs, it should be observed they also prove their worth in areas other than those routine aspects previously mentioned. The family physicians in our group frequently mention the value of discussing cases with the PAs and feel this exercise often brings to light a fresh aspect on the case in point. The majority of PAs have been trained in University Medical Centers and, as a result of that exposure, have become familiar with current medical practice. Given this background the PA is capable of bringing fresh insights into most medical practices.

### COST EFFECTIVENESS

The cost effectiveness of a PA, or for that matter any physician extender, has been discussed previously.<sup>12</sup> A case can be made either for or against an increased financial yield as a result of incorporating a PA into one's practice. Our group, after working with physician's assistants and having an opportunity to compare the type of practice currently experienced versus previous solo practice experience, believes the uniqueness of the PA is his ability to serve as a buffer (other forms of health extenders could undoubtedly be substituted for the PA but since our experience is limited to PAs it would be improper to comment here).

Our system of care is a viable one and represents an improvement over the more traditional forms of primary care, especially solo general practice common to rural America. Previous attempts to recruit more physicians to rural practice, at least in the State of Iowa, have not been successful. The system we are testing, utilizing the PA to modify some of the undesirable aspects

of rural practice, will provide a much more attractive recruiting model for family physicians.

In an effort to document the effectiveness of our program we are working with a team of health care evaluators from the University of Iowa Department of Family Practice. This team helps us gather data regarding patient compliance and patient satisfaction. Also, the gradual introduction of a problem oriented medical record system and patient care protocols, problem indexing and other procedures will aid us in assessing the quality of our out-patient medical care. 13 It is too early to report in any detail on the results of this evaluation but the full data will be reported at a later date. Preliminary results indicate a high degree of patient satisfaction. Perhaps more importantly for the purposes of this discussion, the physicians involved all believe this model has allowed them to practice medicine in a manner that is satisfying while enabling continued professional growth. The physician's assistant in his role as a "buffer" for the physican can make a potentially significant contribution to the health care system in this country, particularly in a rural primary care setting.

### **ACKNOWLEDGMENT**

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The references noted in this article may be obtained from the author or the journal of the iowa medical society.

# FEELING GOOD

Each Wednesday, beginning November 20, over the public television network in Iowa, a unique health education series will be presented. The onehour show will be telecast at 7 p.m. and will continue for 26 weeks. The "Feeling Good" health education series is produced by the creators of Sesame Street and has been called "television's most ambitious effort to convey health information."

It will take a positive, practical and sometimes humorous approach to such topics as cancer, heart disease, hypertension, child care, etc.

# Bowel Damage After Radiation Therapy of Carcinoma of the Cervix

JOHN J. PTACEK, M.D. lowa City

THE CURE RATE for epidermoid carcinoma of the cervix has increased markedly in the past 20 years<sup>3</sup> (Table I).

This trend is due to several factors. The PAP smear has made early detection of the cancer possible, and as more women take advantage of the simple screening procedure on a routine basis, more lesions are detected in the in-situ stage when the cure rate is nearly 100% by total abdominal hysterectomy. Approximately 60% of all the carcinoma of the cervix cases in Iowa are now being detected in the in-situ stage.

TABLE I

CARCINOMA OF THE CERVIX. INCLUDES CARCINOMA

IN-SITU AT UNIVERSITY HOSPITALS

Five Year Relative Survival								
Year	N	umber of Cases	All Stages (%)	(In-situ,	Regional (Stage II, III, IV) (%)			
1938-1949		873	50	59	27			
1950-1959		972	65	69	34			
1960-1969	• • • • • • • • •	1,135	75	76	47			

A second factor in the improved survival rate has been the use of  $Co^{60}$  or other megavoltage therapy which has made it possible to treat the whole pelvis to higher doses than could be achieved with orthovoltage x-ray units. The use of megavoltage units has been accompanied by increased survival rates of approximately 50% in

Importance is cited of physician awareness to the increasing incidence of radiation damage to the bowel among patients treated for invasive carcinoma of the cervix. Care of these patients can present a difficult challenge.

Stages I, II, and III carcinoma of the cervix.<sup>5</sup> Such equipment (Co<sup>60</sup>, linear accelerator, betatron) is a must in the treatment of cervical carcinoma in any except the very earliest stage (Ia) of invasive cancer where radium alone may suffice.

With the increasing cure rates there has been a concomitant increase in the incidence of radiation damage to bowel and bladder. 1, 5 The skin reaction is usually not a limiting factor with megavoltage therapy, and the higher doses which can be delivered to the cancer are also delivered to the rectum, sigmoid, and ilium and bladder. At the present time there are over 1,000 women living in Iowa who have had radical radiation therapy for carcinoma of the cervix who are at risk for the complications of that therapy. There are a smaller number of women who have had radical radiation therapy for adenocarcinoma of the uterus and an undetermined number of people who have had high dosage radiation therapy for carcinoma of the bladder or prostate who would be at similar risk. In the past three years 14 patients have had surgery at University Hospitals for bowel damage occurring as a result of radiation therapy for carcinoma of the cervix; three of these patients have died as a result of the bowel complications after one or more surgical procedures. It therefore behooves all physicians to be aware of that history in their patients and of the possible complications of radiation therapy.

Radiation damage to bowel can be thought of as

Dr. Ptacek is an associate in the Department of Radiology at the University of Iowa College of Medicine.

occurring in roughly three clinical periods<sup>4</sup> (see Tables II-VII).

Fortunately, the small bowel complications are not as common as the rectosigmoid injuries as they are more difficult to diagnose and care for.

TABLE II

# RADIATION DAMAGE TO SMALL BOWEL ACUTE CLINICAL PERIOD

TIME: Starts third to fourth week of therapy after 2000-3500 rad.

SYMPTOMS: Intermittent cramps, Frequent, watery stools.

DIAGNOSIS: Studies are rarely needed for diagnosis. Motor meal may show decreased transient time. Experimental studies have shown malabsorption of glucose, fats, and electrolytes and have demonstrated protein loss into the bowel.

TREATMENT: Symptomatic. Antidiarrhea medication.

PROGNOSIS: Good. Usually self-limited with symptoms lasting only a few days to several weeks after therapy.

TABLE IV

# RADIATION DAMAGE TO SMALL BOWEL CHRONIC CLINICAL PERIOD

TIME: One to many years after therapy.

SYMPTOMS: Intermittent abdominal pain, sometimes with vomiting.

DIAGNOSIS: Abdominal distension.

Motor Meal: Irregular diameter of small bowel with areas of dilatation, stenosis.

Anemia and low serum protein.

TREATMENT: Low residue, high protein, high caloric diet. Antispasmotics. Surgery usually is eventually required—is difficult.

PROGNOSIS: When damaged bowel is removed or diversion is accomplished the prognosis is good as the patients have usually been cured of the cancer.

### TABLE VI

# RADIATION DAMAGE TO RECTUM AND COLON SUBACUTE CLINICAL PERIOD

TIME: Six months to two years after therapy.

SYMPTOMS: Rectal bleeding. May be painful.

DIAGNOSIS: Proctoscopic. Granular mucosa with telangectasia.

Often ulceration which may be associated with an inflammatory mass in the rectovaginal septum.

TREATMENT: Low residue diet. Antidiarrheics. Cortisone suppositories may help symptomatically. Surgery is usually not necessary except for persistent symptoms or heavy bleeding, then colostomy is necessary.

PROGNOSIS: Usually good. May progress to rectovaginal fistula or rectal stenosis.

The small bowel is actually more radiosensitive than is the colon, but its mobility keeps it from being in the treatment field as consistently as is the rectum. A patient who has had previous abdominal surgery or pelvic inflammation is more

### TABLE III

# RADIATION DAMAGE TO SMALL BOWEL SUBACUTE CLINICAL PERIOD

TIME: Six months to two years after therapy.

SYMPTOMS: Sudden onset of acute abdomen.

DIAGNOSIS: Clinical and x-ray findings of partial or complete small bowel obstruction.

TREATMENT: Intestinal tube decompression. Almost always need laparotomy—surgical findings of an isolated segment of gangrenous bowel, sometimes perforation.

PROGNOSIS: Guarded. Repeat episodes are frequent. Surgery is difficult.

### TABLE V

# RADIATION DAMAGE TO RECTUM AND COLON ACUTE CLINICAL PERIOD

TIME: Third to fourth week of therapy, 2000-4000 rad.

SYMPTOMS: Frequent, small, soft stools. Tenesmus.

DIAGNOSIS: Clinical. Proctoscopic examination would show hyperemic, edematous mucosa.

TREATMENT: Antidiarrheics, low residue diet.

PROGNOSIS: Good. Symptoms usually subside a few days to a few weeks after therapy is completed.

### TABLE VII

# RADIATION DAMAGE TO RECTUM AND COLON CHRONIC CLINICAL PERIOD

TIME: One year to many years after therapy.

SYMPTOMS: Crampy pain. Diminished caliber of stools. Occasional obstruction.

DIAGNOSIS: Usually has diffuse pelvic fibrosis. Proctoscopic examination: thick, pale mucosa. Barium enema: "Lead pipe."

TREATMENT: Lubrication of stools and low residue diet. Surgical intervention for high grade obstruction.

PROGNOSIS: Good.

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likely to have adhesions which fix small bowel in the pelvis, making it more likely to sustain radiation damage.

Any surgeon who has dealt with a radiation damaged bowel will attest to the difficulties which can be encountered with the healing of anastomoses and wounds, the frequency of recurrence of stenotic segments, and problems with maintaining nutrition. Long-term or repeated hospitalizations are not uncommon.

Another major difficulty is in making the proper diagnosis. Often the symptoms and signs are similar to those caused by recurrent or persistent cervical neoplasm. Careful evaluation of the patients is necessary. In most cases there is a good chance of long-term survival if the symptoms are secondary to radiation damage. Second primaries are also found occasionally in these women. It has been suggested that irradiated bowel is susceptible to development of adenocarcinoma.2 These patients are also potentially curable. It must be noted that the symptoms of radiation damage may occur years after the radiation therapy.

# STATE DEPARTMENT OF HEALTH

(Continued from page 504)

elapsed since the last toxoid injection, one finds that within 4 to 7 days following booster injection nearly all (approximately 90%) will have an antibody rise to protective levels and within 14 days 100% will be protected.<sup>1, 3</sup>

Recently, some2, 4 have argued against excessive use of tetanus toxoid boosters. They point out the increasing incidence of untoward reactions to tetanus toxoid associated with high tetanus antibody titers. They also suggest that frequent toxoid administration leads to a qualitative change in antibody type with the development of skin sensitizing antibodies. In 45 children studied, 1 to 9 years after their last toxoid injection, the lowest antibody level for any child was 0.4 AU/ml, 40 times the protective threshold. These authors observe that "routine" tetanus immunization is provided as a part of many social-institutional involvements, such as entering summer camp, elementary and secondary schools, colleges, and changing occupations. Often physicians give

### SUMMARY

- 1. Radiation damage to bowel is increasing in frequency in patients treated for invasive carcinoma of the cervix (as is the cure rate).
- 2. Symptoms of bowel damage can occur many years after the therapy and may be confused with recurrent cancer or development of a primary bowel cancer.
- 3. The care of patients presents a difficult challenge to physicians, but every effort must be made to provide proper care for these women who many times have been cured of their cervical can-

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a reinforcing booster whenever asked to care for a skin break regardless of the time since previous tetanus immunization. Many institutions and employers require that their workers receive annual tetanus boosters.

What all this means is that many people are over-immunized with tetanus toxoid. The aforementioned findings support the argument that in the fully immunized individual routine boosters need only be given at 10-year intervals. Also, that following injury in the fully immunized if less than 5 years have elapsed since the last toxoid injection, we can be confident that protective levels of tetanus antibodies are circulating. Therefore, a booster need not be given. Obviously, if tetanus immunization is incomplete at the time of the wound, the remainder of the recommended series should be given and passive protection with tetanus immune globulin considered.

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M. E. ALBERTS, M.D., Scientific Editor

To each of you from all of us, a very Joyous Holiday Season.

# CHRISTMAS LIGHTS

One of my fond memories of Christmas is the beauty of a simply-decorated pine tree lighted by candles. It was tradition in our family to spend Christmas eve at the home of my grandmother; first, to attend services at a small German Lutheran church; later, the lighting of the Christmas tree. The church services were impressive with the children having their part to play in relating the story of the Christ child's birth; and everyone joined in singing the lovely hymns. Silent Night, Holy Night to me is much more beautiful as Stille Nacht, Heilige Nacht, the way it was originally written. But, that candle-lighted tree was a true wonder to behold. Today, such a treat is overshadowed by safety standards, but the memory lingers on.

A Chinese proverb says, "it is better to light one candle than to curse the darkness." Those small candles on the simple pine tree should remind us of our place on earth. This is especially so very true during the season of lights when our faith is renewed in the remaining few days of another year. Can the light cast by many tiny candles penetrate the cataract of our minds to realize the significance of the season? We, as physicians, must be reminded of our calling to mend the lame and heal the sick. We must seek the truth about ourselves and our profession. Dishonesty and de-

ceit belong in the darkness; truth is akin to the light. Our thoughts in the ministry to our patients must be embodied with hope and love, faith and truth, in a measure acceptable to the Great Physician whose birth we celebrate.

Our society has many demands. We become more burdened each month and year by regulations and procedures which may appear to cast a dark shadow over our primary mission. We cannot ignore the demands of the whole society; vet we must help society from becoming entrapped in the entanglements of the bureaucrats who often seem to be lurking in the darkness of politics unable to face the light of truth and true brotherly love. If we, as members of a noble profession, continue to be true to our patients they will be our allies in maintaining a society free of corrupt practices. Such can be as sure and precise as a surgeon's sharp knife, cutting out the disease that renders unhealthy the body of society. May each of you be reminded of these things with the vision of each candle during this season of lights. Though the darkness seems very dense, a tiny candle can penetrate it in a measure that will amaze each beholder. Keep the candles lighted to guide us in our day-to-day endeavors, to cast away cynicism, and bitterness, and greed.—M.E.A.

# **Educationally Speaking**

by RICHARD M. CAPLAN, M.D.

# ON THE NECESSITY OF RE-INVENTING THE WHEEL

I suspect almost unanimous agreement could be had from any individual or group in modern society, that "re-inventing the wheel" is something to be avoided at all costs and for all circumstances. For is it not wasteful, unnecessary, silly, stupid, and perhaps even downright evil to go over previously trod ground, repeat mistakes others have made, ignore the progress of the past? Should we not always move forward into the future from the plateau built by our forebears?

Well, now just a minute! Are we dealing with another of those pieces of conventional wisdom that may not well survive close analysis? Consider basic skills of living—walking, speaking, learning the three R's, loving. Surely these must be developed from a ground zero of incompetence, to be built anew by each of us, since we are denied the rich lode of ready-made behavior provided by "instinct" to biologic forms less well developed than we.

But what about complex behavior and technological progress—can't we simply move forward? Yes, most of the time, but only after taking the often great pains to find out where we are! That means a prodigious effort must be given

Dr. Caplan is Associate Dean, Continuing Medical Education at The U. of I. College of Medicine.

to studying what is already known. If our experience and study are indeed broad and deep enough, we may learn that a wheel has been invented. Without such breadth and depth, we're unlikely to know, and so embark on the re-invention.

For each of us learning is a unique circumstance. Daily problem-solving has its flashes of insight which surely must duplicate the feeling of exhilaration which accompanied the invention of the wheel. An outside observer would tell us, or we later discover, that perhaps ours wasn't a unique situation and solution at all. Yet most of us deal only rarely with new problems. Our dayto-day personal and professional functioning involves rote activity and application of fairly standard solutions to standard problems. But even granting the seeming repetitiveness of much of our activity, Heraclitus was surely right: We can't step into the same river twice. And so our problem-solving must be modified by the tiny ways in which one problem is different from every other.

When we reach the end of our days, we may reflect and denigrate ourselves that we "only" reinvented the wheel. But I submit that is too harsh a criticism, for the wheel is modified slightly by what each of us has done to it and with it. Although our work and lives seem such a tiny speck in what constitutes eternity, our existence—the activity and contribution made by each of us—is exactly what causes those alterations that make it impossible to step into that same river twice.

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## Morbidity Report for October, 1974

D <i>i</i> seose	October 1974	1974 to Date	1973 to Date	Most October Coses Reported From These Counties	Diseose	October 1974	1974 to Dote	1973 to Dote	Most October Coses Reported From These Counties
Actinomycosis	1	2		Mahaska	Meningitis,				
Amebiasis	2	30	77	Boone, Jackson	aseptic assoc.				
Brucellosis	2	16	5	Dubuque, Louisa	with ECHO	4 4	16	1	Polk
Chickenpox	464	6743	11150	Buena Vista, Marshall, Story	Meningitis, aseptic assoc.				
Combined					with ECHO I	1 1	- 1		Polk
infestations	ı	5		Johnson	Meningitis,				
Conjunctivitis	147	737	886	Scattered	bacterial	ı	6	5	Black Hawk
Cytomegaloviru					Meningitis,				
infection	2	34		Cedar, Dubuque	bacterial due				
Eaton's agent					to Mimo				
infection	ı	28	18	Grundy	Polymorpha	1	- 1		Polk
Echovirus type		17		Allamakee, Jackson, Polk	Meningitis, type				
Encephalitis, typ					unspecified	6	37	28	Scattered
unspecified	. 2	14	15	Linn, Scott	Meningococcal				
Encephalitis, vir		17	8	Muscatine	Meningitis	- 1	7	20	Page
Encephalitis, vir assoc. with	al				Meningoencepha assoc. with	alitis			Jackson
ECHO 4	1	4		Polk	ECHO 4	1	- 1		
Erythema					Mumps	120	1790	3238	Muscatine, Union,
infectiosum	9	546	1342	Winnebago	•				Woodbury
Gastrointestinal					Pediculosis	94	424	165	Black Hawk, Linn,
viral inf.	2398	9262	6020	Buchanan, Cerro Gordo,					Muscatine
				Madison	Pertussis	1	14		Wapello
Giardiasis	4	42	17	Iowa, Monona, Polk,	Pinworms	5	57	- 11	Polk
				Winnebago	Pneumonia	72	783	953	Scattered
Hepatitis, A					Rabies in				
(Infectious) Hepatitis, B	17	230	171	Dallas, Palo Alto, Polk	Animals	6	112	196	Franklin, Grundy, Sioux, Story
(Serum)	7	76	43	Boone, Johnson,	Dhaumatia favor	- 5	52		Sac, Winneshiek
				Montgomery, Polk	Rheumatic fever		187	122	· ·
Hepatitis, type					Ringworm, body		12	4	Harrison, Lyon, Story
unspecified	9	39	19	Dallas, Polk, Scott	Ringworm, scalp			4	•
Herpes simplex	13	101	59	Johnson, Monroe,	Roseola	1	15		Johnson
				Muscatine, Polk	Salmonellosis	24	180	177	Scattered
Herpes zoster	2	38	18	Black Hawk, Scott	Scabies	33	104	20	Black Hawk, Louisa, Pol
Impetigo Infectious	157	463	350	Scattered	Shigellosis Streptococcal	42	275	258	Delaware, Dubuque, Pol
Mononucleosi	is 120	843	607	Black Hawk, Johnson, Linn	infections	662	8330	5618	Scattered
Influenza-like					Trichuriasis	2	5		Johnson
illness	3019	94894	12422	Cerro Gordo, Chickasaw, Madison	Tuberculosis, active	16	104	109	Scattered
Leprosy	- 1	- 1		Cass	Tuberculosis,	10	.0.7	,	
Listeriosis	1	- 1		Polk	inactive	2	11		Scattered
Malaria,					Venereal Diseas		•		
P. malorioe	- 1	- 1		Crawford			E107	5219	Black Hawk, Linn,
Malaria,					Gonorrhea	547	5197	5217	Polk, Scott
P. vivox	1	- 1		Polk			201	2/0	· · · · · · · · · · · · · · · · · · ·
Meningitis,					Syphilis	12	321	360	Linn, Marshall, Polk,
aseptic	3	52	14	Clayton, Polk, Scott					Scott



by TENORA MEYER, CMA

#### 1974 LEADERS

This is a year-end salute to the 1974 chapter presidents: Black Hawk County Chapter—Charlotte Lewis CMA-C; Des Moines Chapter—Don-

na Haney; Linn County Chapter—Velma Goettel; Mason City Chapter—Phyllis Kavars; Scott County Chapter—Roma T. Brown, and Woodbury County Chapter—Winnie Donovan CM-A.

Davenport is the site of the next state convention—to be held April 11, 12, 13, 1975.

#### PATIENT PREPARATION

The medical assistant can assist the physician greatly if she uses a tactful and kindly attitude when preparing the patient for an examination. A simple explanation of the examination can put the patient at ease and maximum cooperation will result. Obtaining information from the patient, as requested by the physician, is the first step. The recording of vital signs, the preparation of laboratory slips, the pre- and post-examination contact, should be done according to instructions from the

physician. Removal of clothing may be embarrassing to the patient and great tact should be used in explaining this in relation to the type of examination to be performed. Draping follows—protecting the patient's modesty.

The medical assistant should not leave the examining room while an examination is in progress without the permission of the doctor.

Do you know the examination positions by name? This quiz will test your knowledge—simply match the name of the position with the directions in the opposite column.

- **Dorsal Recumbent** 1. Patient on knees with chest resting on
  - table.
- Sims
- 2. Patient on back with lower limbs flexed and rotated outward.
- Trendelenburg
- 3. Patient in dorsal decubitus with hips and knees flexed, thighs abducted and externally rotated.

- Knee-Chest
- Lithotomy
- 4. Patient is supine on table or bed, head is tilted downward 30-40 degrees and table or bed angulated beneath knees.
- 5. Patient on left side with chest, right knee and thigh drawn up, left arm along the back.

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

Answers: 2, 5, 4, 1, 3

# **About IOWA Physicians**

Dr. Lawrence Den Besten, vice chairman, U. of I. Department of Surgery, is on first professional advisory board of United Ostomy Association. Dr. Den Besten was a primary organizer two years ago of Iowa City Area Ostomate chapter which is affiliated nationally. . . . Dr. Thomas Graham, Iowa Falls, was guest speaker at recent meeting of Iowa Falls Young Mothers Club. He discussed child safety in the home with special emphasis on poisonous house plants. . . . Dr. Richard Fowler. formerly of Atlantic, has joined the U. of I. Department of Psychiatry as assistant professor. Dr. Fowler is a U. of I. medical graduate, interned in Memphis, Tenn., and had a psychiatric residency at Washington University School of Medicine in St. Louis, Mo. . . . Dr. John E. Rawls, Ottumwa, has earned the 1974 AMA physician's recognition award.

Dr. G. A. Chalian, Clinton, addressed the first Medical World Congress of Armenian Doctors in Beirut, Lebanon, in October. Dr. Chalian discussed medical advancements in urology. . . . Dr. Philip R. Hastings, Waterloo, is new member of the Iowa Committee on Mental Hygiene. Dr. Hastings is medical director of Northeast Iowa Mental Health Center and is in private practice at Northeastern Psychiatric Clinic in Waterloo.

Dr. Charles Read, professor, Department of Pediatrics, U. of I. College of Medicine, is new president of Iowa Diabetes Association. . . . Dr. James L. Knott, Council Bluffs, recently attended the American Society of Internal Medicine Conference in New Orleans, La. Dr. Knott is president elect of Iowa Society of Internal Medicine. . . . Dr. Donald E. Boyle, Sioux City, recently appeared on KSCJ Open Line Program. Dr. Boyle's topic: "Breast Cancer." . . . Drs. John Doran, Paul Koellner, William C. McCormack, David Wall and David M. Wall, Ames, participated in

a recent nursing workshop supported by Iowa Division, American College of Obstetrics and Gynecology, and held at Iowa State University. . . . Dr. Gerald Solomons, professor of pediatrics, U. of I. College of Medicine, discussed child abuse from the physician's standpoint at recent seminar at Indian Hills Community College in Ottumwa. . . . Eight Fort Dodge physicians recently hosted a dinner in Des Moines for 16 doctors finishing residencies at Des Moines hospitals. Wives were invited. Dr. Maurice E. Kraushaar, president, Webster County Medical Society, said the dinner was held to inform young doctors of opportunities in Webster County.

Dr. Barry Knapp, Sioux City, was guest speaker at recent Sioux City meeting of law enforcement, ambulance and rescue personnel from Iowa, Nebraska and South Dakota. Dr. Knapp's topic was "The Management of the Death Scene-Homicides, Suicides and Accidental Deaths." . . . Dr. E. E. Gamet retired from full-time practice in Lamoni October 6. He was honored at a Chamber of Commerce luncheon for his 40 years of medical service to the community. Dr. Gamet has served on the Lamoni City Council, School Board and Library Board. He is vice president of Lamoni State Bank and president of State Board of Health. In 1970 Dr. Gamet received the IMS Merit Award for outstanding service to the medical profession. Dr. and Mrs. Gamet will winter in Sahuarita, Arizona. They plan to continue to operate their Lamoni farm. . . . Dr. Paul Seebohm, associate executive dean, U. of I. College of Medicine, was recently elected chairman of Iowa Regional Advisory Group (IRMP).... Dr. W. H. Verduyn, Reinbeck, has been appointed medical supervisor of new rehabilitation department at Schoitz Memorial Hospital in Waterloo.

Dr. Raja M. Junaid, director of professional education and research at Independence Mental

Health Institute, has been named a Diplomate of American Board of Psychiatry and Neurology.... Dr. Frank Coyle, Waterloo, was guest speaker at recent meeting of Black Hawk County unit of Iowa Heart Association. Dr. Coyle explained peripheral vascular disease. . . Dr. Howard B. Latourette, professor of radiology, U. of I. College of Medicine, was guest speaker at recent meeting of Washington Rotary Club. Dr. Latourette's subject: "Cancer." . . Dr. Jack Layton, former professor of pathology at U. of I. College of Medicine and currently head of pathology at University of Arizona, was recently awarded an honorary degree at Luther College in Decorah. Dr. Layton is a 1939 graduate of Luther College.

Dr. Edward Hertko, Des Moines, was guest speaker at a recent meeting in Perry for diabetics, their families and friends. . . . Dr. Lynn W. Thompson, Red Oak, will fill the unexpired term of the late Dr. Oscar Alden, Red Oak, as both Montgomery County Medical Examiner and physician member of the County Board of Health. . . . Dr. John W.

Thornton, Lansing physician for 57 years, recently announced his retirement from active practice. Dr. Thornton's father established a medical practice in Lansing in 1880. Dr. Thorton joined his father in 1917. For almost 100 years Lansing has had a Dr. Thornton, a goal which Dr. John W. Thornton, life member of Iowa Medical Society, had hoped to attain. . . . Dr. Rubin H. Flocks, professor (emeritus), Department of Urology, U. of I. College of Medicine, was guest speaker at a recent meeting of the Wapello County Medical Society. Dr. Flocks spoke on carcinoma of the prostate. . . . Dr. Thomas M. Folcy has joined Drs. Donald S. Reading and Robert L. Mandsager in surgical practice in Marshalltown. A graduate of Creighton University School of Medicine, Dr. Foley interned at University of Kentucky Medical Center and had a general surgery residency at U. of I. College of Medicine.

**Dr. Lee McClenahan,** Sigourney, was guest speaker at recent meeting of Sigourney Lions Club. Dr. McClenahan discussed preventive medicine. . . .



Dr. Donald Ahrenholz, Waterloo, was guest speaker at recent meeting of Black Hawk chapter of American Association of Medical Assistants. . . . Dr. Richard Reel, D.O., and Dr. Dale Grunewald, D.O., recently announced the opening of University Medical Center, P.C. in Des Moines. Dr. Grunewald recently completed his internship

#### **DEATHS**

Dr. A. J. Schroeder, 67, Marshalltown, died October 29 at his home. Dr. Schroeder received the M.D. degree at U. of I. College of Medicine and interned at Spokane, Washington. He located in Marshalltown in 1936 and retired in 1972 due to ill health. Dr. Schroeder was a charter member of American Society of Abdominal Surgery and member of Iowa Medical Society and American Medical Association.

Dr. Carl E. Sampson, 79, Creston, died October 1 at Greater Community Hospital in Creston. Dr. Sampson received the M.D. degree at U. of I. College of Medicine and completed his postgraduate work at Harvard University and University of Pennsylvania. A native of Creston, Dr. Sampson had practiced medicine in his home town since 1927. He was a member of Iowa Academy of Ophthalmology and Otolaryngology, member of Iowa Medical Society and American Medical Association.

Dr. Richard W. Driver, 66, Waterloo, died October 15 at Schoitz Memorial Hospital. Dr. Driver received the M.D. degree at the U. of I. College of Medicine in 1933 and interned at the University of Nebraska. He established his medical practice in Waterloo in 1934 and was the founder of Medical Associates. Dr. Driver served for 10 years as Black Hawk County health physician. He was a member of American Association of Family Practitioners, Iowa Medical Society and American Medical Association.

Dr. V. D. Freuch, 84, former Carson physician, died October 17 at Parkview Manor in Reinbeck. Dr. French received the M.D. degree at Rush Medical School in Chicago, Illinois. He practiced medicine in Carson from 1918 to 1944. In 1952, Dr. French returned to Iowa and served as Student Health Director at University of Northern Iowa in Cedar Falls until his retirement in 1965. He was a member of Iowa Medical Society and American Medical Association.

at Des Moines' Mercy Hospital. Both physicians are deputy Polk County Medical Examiners. . . . Dr. Deepak Midha, Creston, spoke at recent meeting of Greater Community Hospital Auxiliary in Creston. Dr. Midha discussed differences between U. S. medical practice and that in his homeland, India.

Dr. I. C. Jerdee, 87, Clermont, died September 17, at Community Memorial Hospital in Postville. Dr. Jeredee received the M.D. degree at the Chicago College of Medicine in 1917 and interned at Lutheran Deaconess Hospital in Chicago. He began his medical practice in Clermont in 1919 and retired in 1970. Dr. Jeredee was a life member of the Iowa Medical Society and American Medical Association.

Dr. William S. Markham, 53, Harlan, died October 12 while vacationing in Missouri. A Harlan physician for 19 years, Dr. Markham received the M.D. degree from Creighton University School of Medicine and interned in the Navy during the closing months of World War II. In 1955, he joined Dr. R. E. Donlin in Harlan. Dr. Markham was Shelby County Medical Examiner; board member of Health Planning Council of the Midlands, past director of Harlan Chamber of Commerce and was re-elected in September to his second term on Harlan Community School Board. He was a member of Iowa Medical Society and American Medical Association.

Dr. Lawrence D. Smith, 79, Des Moines, died October 30 at Iowa Methodist Hospital. Dr. Smith received the M.D. degree at U. of I. College of Medicine and interned at Kansas City General Hospital in Kansas City, Missouri. An obstetrician and gynecologist, Dr. Smith retired from the active practice of medicine in 1972. He was a member of Iowa Medical Society and American Medical Association.

Dr. Earl E. Gingles, 79, Onawa, died October 25 at Burgess Memorial Hospital. A graduate of University of Nebraska School of Medicine, Dr. Gingles had been in medical practice in Onawa since 1933. He was a member of Iowa Medical Society and American Medical Association.

Dr. Leonard Nelken, 59, Clinton, died October 21 while vacationing in New York City. Dr. Nelken received the M.D. degree at Louisiana State University in Baton Rouge, La., and had been a Clinton physician for more than 30 years. He was a member of Iowa Medical Society and American Medical Association.

# JOURNAL/IOWA MEDICAL SOCIETY INDEX TO VOLUME LXIV NUMBERS 1-12 (1974)

About Iowa Physicians	
	518
	274 168
Acute bacterial endocarditis with septic emboli, Ching L.	399
Chiu, M.D., and James D. Roelofs, M.D. Add 16,689 in 1973	434 398
Against minibikes for children (editorial)	208
M.D. Allergic 4.4%	242 474
Anatomy, Terence H. Williams, Ph.D., M.D.  Anderson, Betty Jane, Hospital governing board and medical	140
staff relationships	$\frac{52}{140}$
Anesthesia, Jack Moyers, M.D. Angiomyolipoma of kidney: report of two cases studied angiographically, Steven H. Cornell, M.D., and Robert A. Roldus M.D.	140
Boldus, M.D	25 68
Annual university issue (editorial)	170
Approve degrees	$\frac{442}{106}$
Approve degrees  Arkee, M. S. K., M.D., James M. Caterine, M.D., F.A.C.S. Sudhir Jaituni, M.D, Mediastinal myxoma: case report  Attack on manpower shortage moves ahead, In the Public Interest	107
Attack on manpower shortage moves ahead, In the Public Interest	477
Ballantine, H. Thomas, M.D., Chiropractic and public law	
92-603Battered child, Harold A. Young, J.D.	$\frac{7}{438}$
Bennett, F. W., M.D., Question Box	227
Chester F. McClure, M.D., Physician and alcoholic Berg, John W., M.D., Cancer in Iowa—1970	233 65
Berg, John W., M.D., Edward E. Mason, M.D., Mary Nance, Christian E. Radcliffe, M.D., and Joseph Scotto, Skin	
cancer in Iowa	$\frac{469}{141}$
Bishop, James F., M.D., Reflections on colon surgery	$\frac{391}{149}$
Blythe, James G., M.D., Herbert J. Buchsbaum, M.D., and William A. Davis, M.D. Office detection of covided neo-	143
Ballantine, H. Thomas, M.D., Chiropractic and public law 92-603	387
plasia .  Boldus, Robert A., M.D., and Steven H. Cornell, M.D., Angiomyolipoma of kidney: report of two cases studied angiographically  Bowel damage after radiation therapy of carcinoma of cervix,	25
Bowel damage after radiation therapy of carcinoma of cervix,	
John J. Ptacek, M.D.  Buchsbaum, Herbert J., M.D., William A. Davis, M.D., and James G. Blythe, M.D., Office detection of cervical neo-	510
plasia Office detection of cervical neo-	387
Callis, Manuel N., M.D., and Raymond F. Sheets, M.D., Multiple myeloma in Iowa	
Multiple myeloma in Iowa	$\frac{429}{65}$
Caplan, Richard, M.D., Charles Linden, M.A., and John Murphy, M.D., Patient care evaluation in an Iowa hospital	61
Caplan, Richard M., M.D., and Thomas Yorcheski, B.A., Survey of continuing medical education in Iowa	159
Caraway, L. D., M.D., Question Box	$\frac{195}{141}$
Cataract "roto-extractor" (editorial)	117
and M. S. K. Arkee, M.D., Mediastinal myxoma: case report	107
report Chiropractic and public law 92-663, H. Thomas Ballantine, M.D.	7
Chiu, Ching L., M.D., and James D. Roelofs, M.D., Acute	434
Christmas lights (editorial)	513
Clancy, John, M.D., Ming-Tso Tsuang, M.D., Barbara Norton, MSW, and George Winokur, M.D., 10wa 500: comprehensive study of mania depression and schleophenia	394
Clifton, James A. M.D. Internal Medicine	$\frac{142}{167}$
College thanks Iowa preceptors  Connor, William E., M.D., Philip A. Habak, M.D., and Helmut G. Schrott, M.D., Coronary primary prevention trial	19
Continuing Education Courses and Conferences	
Cooper, Reginald R., M.D., Orthopaedic Surgery	$\frac{500}{149}$
Angiomyolipoma of kidney: report of two cases studied	0.0
angiographically	25

Coronary primary prevention trial, Philip A. Hab Helmut G. Schrott, M.D., and William E. Connor, County Society officers Credit code, Iowa consumer	M.D	$\frac{19}{276}$
Davis, William A., M.D., Herbert J. Buchsbaum, James G. Blythe, M.D., Office detection of cerve plasia.  Deaths	, 446, 487, uld know H., Ph.D., he Public lipectomy	348 520 245 442 348 141 152 23 31 401 238
Eager beaver tendency (editorial)  Eavesdropping on the doctor and his patient, In to Interest  Eckstein, John W., M.D., Dean, U. of I. College of Statement from  Educationally Speaking  18, 72, 106, 210, 247, 364, 405	Medicine,	120
Educationally Speaking	f. Kaung,	463 33
Family practice progress		
Good medicine: good manners (editorial)	uld know , Richard	348 250
Habak, Philip A., M.D., Helmut G. Schrott, M. William E. Connor, M.D., Coronary primary primary primary primary primary primary primary from tice residency.  Hein, Herman A., M.D., Physician's assistant as delivery of primary care	revention hily prac- buffer in ng, M.D., he Public	
IMS part of bustling university scene in April, In the Interest	ge moves ina visit) cnt) 123, , (Foun- ation for describes ling uni- on goal— is \$65,113	171 94 441
Index to minutes		335 521

Medical Society  Installation Remarks—sees understanding as most important, Ralph L. Wicks, M.D. Instant learning (editorial) Internal Medicine, James A. Clifton, M.D. Iowa consumer credit code Iowa 500: comprehensive study of mania, depression and schizophrenia, John Clancy, M.D., Ming-Tso Tsuang, M.D., Barbara Norton, MSW, and George Winokur, M.D. Iowa Foundation for Medical Care, Report to IMS House of Delegates Iowa's immunization goal—total eradication, In the Public Interest Iowa Medical Miscellany	307 269 245 142 465 394 302 426 497 153	Ome shot medical Society On roses and prescribing (editorial) On writing editorials (editorial) One shot medicine (editorial) Ophthalmology, Frederick C. Blodi, M.D. Orthopaedic Surgery, Reginald R. Cooper, M.D. Orthopaedic and rehabilitation seminar Otolaryngology and Maxillofacial Surgery, Brian F. McCabe, M.D. Ott, Mary, M.D., ASCP, D. T. Kuang, M.D., and J. A. Koepke, M.D., Estimation of bone marrow iron stores—comparison of smear section techniques  Page County Meeting Pathology, George D. Penick, M.D. Patient care evaluation in an Iowa hospital, John Murphy, M.D., Charles Linden, M.A., and Richard Caplan, M.D. Pediatric Conference Pediatrics, Fred G. Smith, M.D. Penick George D., M.D., Pathology Penningroth, R. Paul, M.D., and Charles H. Steinmeyer, Ph.D., Treatment of anxiety neurosis by alpha and beta adrenergic blocking agents Pharmacology, John P. Long, Ph.D.	170 69 208 149 149 115 150 463 363 150 61 30 151 150
Kaung, D. T., M.D., Mary Ott, M.T., ASCP, and J. A. Koepke, M.D., Estimation of bone marrow iron stores—comparison of smear selection techniques.  Keettel, William C., M.D., Obstetrics and Gynecology  Kelley, John H., M.D., Total knee arthroplasty (preliminary report)  Keogh, What every physician should know about  Koepke, J. A., M.D., D. T. Kaung, M.D., and Mary Ott M.T., ASCP, Estimation of bone marrow iron stores—comparison of smear selection techniques  Krause, Charles J., M.D., and Stefan Demjen, M.D., Aging face	463 144 . 197 499 . 463 . 242	Physical Therapy, Gary L. Smidt, Ph.D.  Physician and alcoholic, Harold F. Moessner, M.D., F. William Bennett, M.D., and Chester F. McClure, M.D.  Physician's assistant as buffer in delivery of primary care, Herman A. Hein, M.D.  Physiology and Biophysics, F. P. J. Diecke, Sc.D.  Porter, J. R., Ph.D., Microbiology  Pratt, Harrison W., II, D.O., Paul From, M.D., and Joseph Torruella, M.D., Pulmonary endometriosis: report of case  Preceptors, College thanks Iowa  President's Page  5, 49, 93, 136, 188, 224, 264, 344, 380, 420, 456,  President's remarks—on quality medical care in Iowa, Rubin H. Flocks, M.D.  Preventive Medicine and Environmental Health, Peter	233 507 152 143 360 167 496 267
Lawyers' contingent fee—protection for physicians, Earl F Rose, M.D., LL.B. Life and Associate memberships Linden, Charles, M.A., John Murphy, M.D., and Richarc Caplan, M.D., Patient care evaluation in an Iowa Hospita Long, John P., Ph.D., Pharmacology Lutz, Bernard L., D.D.S., M.P.H., Ph.D., and John E Goodrich, D.D.S., M.P.H., What every health practitioner should know about preventing dental disease	111 321 1 1 61 1 52	Preventive Medicine and Environmental Realit, Peter Isacson, M.D.  Primary care preceptorships for professors  Prusak, Yechiel, M.D., and Edward J. Drew, M.D., Zollinger-Ellison syndrome  Psychiatry, George Winokur, M.D.  Ptacek, John J., M.D., Bowel damage after radiation therapy of carcinoma of cervix  Pulmonary endometriosis: report of case, Paul From, M.D., Harrison W. Pratt, II, D.O., and Joseph Torruella, M.D.	209 473 153 510
Marston, Robert Q., M.D., Some opportunities and issues ir medicine Mason, Edward E., M.D., Mary Nance, Christian E. Rad- cliffe, M.D., Joseph Scotto, and John W. Berg, M.D. Skin Cancer in Iowa McCabe, Brian F., M.D., Otolaryngology and Maxillofacia Surgery	. 355 - . 469 l	Quality assessment consultation program	502
McClure, Chester F., M.D., F. William Bennett, M.D., and Harold F. Moessner, M.D., Physician and Alcoholic Mediastinal myxoma: case report, Sudhir Jaituni, M.D. M. S. K. Arkee, M.D., and James M. Caterine, M.D. F.A.S.C.  Medical Assistants 32, 76, 122B, 179, 248, 369, 407, 443, 481 Medical liability—top physician concern, In the Publi Interest  Methaqualone: an irrational hypnotic, Dennis K. Helling Pharm.D., and Kirk H. Strong, M.D.  Microbiology, J. R. Porter, Ph.D.  Moessner, Harold, M.D., Question Box  Moessner, Harold, M.D., F. William Bennett, M.D., and Chester F. McClure, M.D., Physician and alcoholic  Moyers, Jack, M.D., Anesthesia  Multiple myeloma in Iowa, Manuel N. Callis, M.D., and Raymond F. Sheets, M.D.  Murphy, John, M.D., Charles Linden, M.A., and Richar Caplan, M.D., Patient care evaluation in an Iowa hospita	1 . 233	Radcliffe, Christian E., M.D., Edward E. Mason, M.D., Mary Nance, Joseph Scotto, and John W. Berg, M.D., Skin cancer in Iowa Rakel, Robert E., M.D., Family Practice Rakel, Robert E., M.D., Question Box Random thoughts at an airport (editorial) Reference committee reports Reflections on colon surgery, James F. Bishop, M.D. Report of IMS Judicial Council Reports of Officers Reports of Special Committees Reports of Standing Committees Report of Treasurer Resolutions Roelofs, James D., M.D., and Ching L. Chiu, M.D., Acute bacterial endocarditis with septic emboli Rose, Earl F., M.D., LL.B., Lawyers' contingent fee—protection for physicians	469 142 462 118 323 391 281 278 289 281 280 318
Nance, Mary, Edward E. Mason, M.D., Christian E. Radcliffe M.D., Joseph Scotto, and John W. Berg, M.D., Skin Cance in Iowa Neurology, Adolph L. Sahs, M.D. New opportunity for physician's nurses New reporter for family physicians (editorial) Norton, Barbara, M.S.W., George Winokur, M.D., Joh Clancy, M.D., and Ming-Tso Tsuang, M.D., Iowa 500 comprehensive study of mania, depression and schizo phrenia Neugent, David, Question Box	r . 469 . 143 . 406 . 117 n :	Sahs, Adolph L., M.D., Neurology Scanlon Foundation loans \$65,113 in 1973-74. In the Public Interest Schrott, Helmut G., M.D., Philip A. Habak, M.D., and William E. Connor, M.D., coronary primary prevention trial Scientific Session, Annual IMS (editorial) Scotto, Joseph, John W. Berg, M.D., Edward E. Mason, M.D., Mary Nance, and Christian E. Radcliffe, M.D., Skin cancer in Iowa Seebohm, Paul M., M.D., Statewide medical education system	228 19 68 469
Obstetrics and Gynecology, William C. Keettel, M.D Office detection of cervical neoplasia, Herbert J. Buchsbaum M.D., William A. Davis, M.D., and James G. Blythe, M.D. Officers and Committees of Iowa Medical Society 1974-1975 .	o. 387	Seebohm, Paul M., M.D., Statewide medical education system for training resident physicians in family practice.  Self-evaluation programs (editorial)	442

-		
Ξ	D	

Skin cancer in Iowa, Edward E. Mason, M.D., Mary Nance, Christian E. Radcliffe, M.D., Joseph Scotto, and John W. Berg, M.D. 469 Smidt, Gary L., Ph.D., Physical therapy 152 Smith, Fred G., M.D., Pediatrics 151 Some opportunities and issues in medicine, Robert Q. Marston, M.D. 355	Treatment of anxiety neurosis by alpha and beta adrenergic blocking agents, R. Paul Penningroth, M.D., and Charles H. Steinmeyer, Ph.D	
State Department of Health	Urology, Rubin H. Flocks, M.D.	15
College of Medicine	Vestling, Carl S., Ph.D., Biochemistry	14
M.D., Treatment of anxiety neurosis by alpha and beta adrenergic blocking agents	What every health practitioner should know about preventing dental disease, Bernard L. Lutz, D.D.S., M.P.H., Ph.D., and John E. Goodrich, D.D.S., M.P.H. What every Iowa physician should know about Keogh Who does the killing? (editorial) Wichern, Homer E., M.D., Disability in Iowa Wichern, Homer E., M.D., Supplemental security income program Wicks, Ralph L., M.D., Installation Remarks—sees understanding as most important Wicks, Ralph L., M.D., The Question Box Williams, Terence H., Ph.D., Anatomy Winokur, George, M.D., John Clancy, M.D., Ming-Tso Tsuang, M.D., and Barbara Norton, MSW, Iowa 500: comprehensive study of mania, depression and schizophrenia Winokur, George, M.D., Psychiatry	49 2 2 11 26 5 14
Thanksgiving (editorial)       475         T. L. C.? (editorial)       362         To expand health sciences information       113         Today's health on TV       122	Yarcheski, Thomas, B.A., Richard M. Caplan, M.D., Survey of continuing medical education in Iowa Young, Donald C., M.D., The Question Box Young, Harold A., J.D., Battered child Your future (editorial)	15 1 43
Torruella, Joseph, M.D., Paul From, M.D., and Harrison W. Pratt, II, D.O., Pulmonary endometriosis: report of case 360 Total knee arthroplasty (preliminary report), John H. Kelley, M.D	Ziffren, Sidney E., M.D., Surgery Zollinger-Ellison syndrome, Yechiel Prusak, M.D., and Edward J. Drew, M.D.	

#### INDEX TO ADVERTISERS

Burroughs Wellcome Co
Iowa State Department of Health 523
Iowa Trust Association
Lilly, Eli, & Company
Medical Protective Company 500
Pharmaceutical Manufacturers Association 502B, 503
Prouty Company
Roche Laboratories
World Wide Health Care Air Force 515

## **ALCOHOLISM DIRECTOR**

Develops and administers a comprehensive program for the treatment and prevention of alcoholism in the State of Iowa.

Minimum Qualifications: Any combination of education and/or experience equivalent to graduate level course-work in hospital, business, behavioral science, public administration, or health areas (medicine, pharmacy) and four (4) years of general administrative experience, two (2) years of which involved experience in handling alcohol problems.

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Contact: Merlin Lee, Personnel Officer
Iowa State Department of Health
Lucas State Office Building
Des Moines, Iowa 50319
Phone (515) 281-3106

"AN EQUAL OPPORTUNITY EMPLOYER"

GENERAL PRACTITIONER NEEDED: Friendly rural community. Moville, Iowa, population 1,200, 14 miles east of Sioux City, Iowa. Unlimited opportunity for a family physician. Phone 712/873-3158 or 712/873-3455.

IMMEDIATE OPENING for Ob-Gyn and Internal Medicine, specialties to establish successful practice with 14-man multispecialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

MEDICAL UNDERWRITER NEEDED—interesting work evaluating risks as well as involvement in the insurance aspect of providing medical care. Secure position with good future and good corporate hours and benefits. Call or write Fred Dinkler, M.D., Medical Director, The Bankers Life, 711 High, Des Moines, Iowa 50307. 515/284-5445.

WANTED—FAMILY PHYSICIAN to associate with four-man clinic. Accredited hospital, full surgical and radiological coverage. Contact Paul Vander Kooi, M.D., Orange City, Iowa 51041. Call 712/737-4938 office or 712/737-4104 home.

TRAUMA CENTER/EMERGENCY ROOM COVERAGE—Mercy Hospital, Cedar Rapids, Iowa. Modern, well-equipped hospital, guaranteed minimum income of \$36,000, 42 hours per week. Excellent staff specialists on call for specialized needs. Progressive city 25 miles from University of Iowa Medical School. Good recreational facilities, excellent school system. Contact Bernard M. Grahek, Mercy Hospital, 701 Tenth Street, S.E., Ccdar Rapids, Iowa 52403. Phone 319/398-6133.

PHYSICIAN, CHIEF OF MATERNAL AND CHILD HEALTH SERVICES—To assume responsibility for the maintenance and supervision of the Maternal and Child Health Program for a City-County Health Department now serving a population of approximately 400,000. Physician, licensed or eligible to practice medicine in Nebraska, Master of Public Health or Board cligible in areas of Preventive Medicine or Pediatrics or equivalent graduate or resident training, Salary range \$29,100 to \$37,090, plus retirement and other fringe benefits. Contact Health Director, City-County Health Department, 3939 Leavenworth, Omaha, Nebraska 68105. Telephone 402/444-7471.

DIRECTOR—ALCOHOLIC TREATMENT CENTER—located in a 676-bed acute care general hospital. This 40-bed unit has functioned successfully for 1½ yrs. based upon a team approach to treatment of the alcoholic. Full time is preferred but some part time private practice is negotiable. Excellent salary with attractive benefits. Interested persons please send curriculum vitae to Donald J. Courtright, Ass't. Admin., Iowa Methodist Hospital, 1200 Pleasant, Des Moines, Iowa 50308.

FOR SALE—100 M.A. GE X-ray; Bucky, fluoro., and all accessories. Write or call Robert Dolan, M.D., 101 College Drive, Decorah, Iowa 52101. 319/382-3133.

WANTED—MEDICAL DIRECTOR—Family practitioner to serve in health clinic. No Sunday or holiday work. Basic 40-hour week. Salary, \$36,000 a year. If interested, please contact Clinic Manager, Evelyn Davis Health Clinic, 1154 5th Avenue, Des Moines, Iowa 50314. Phone 515/283-2571.

CLINIC PHYSICIAN—With special interest in the area of Maternal and Child Health for a City-County Health Department now serving a population of approximately 400,000, Physician licensed or eligible to practice medicine in Nebraska, Contact Health Director, City-County Health Department, 3939 Leavenworth, Omaha, Nebraska 68105. Telephone 402/444-7471.

### LIST YOUR WANTS

WANTED—FAMILY PRACTITIONER to join 8-man multispecialty group. Excellent clinic and hospital facilities. Unusually progressive small community in which to live and raise a family. Excellent salary and benefits, partnership in twelve months, liberal vacation and meeting time. Contact Richard A. Callis, Administrator, McCrary-Rost Clinic, Lake City, Iowa 51449. Telephone 712/464-3194.

GENERAL PRACTITIONER—Psychiatric Hospital. Liberal fringe benefits, Near recreation areas and State Capital. Beginning salary \$27,287 to \$31,806 depending on qualifications. Internship, U. S. citizen and licensure required. Equal opportunity employer. Contact Louis Jensen, M.D., VA Hospital, Knoxville, Iowa 50138.

NEEDED—STUDENT HEALTH PHYSICIAN—Salary negotiable, 40 hour week, month vacation, continuing education. An equal opportunity employer. Contact Harley G. Feldick, M.D., Student Health Service, University of Iowa, Iowa City, Iowa 52242.

WANTED—GP/FAMILY PRACTITIONER in Council Bluffs, Iowa. Salary \$50,000. After 2 years, if agreed by both parties, full partnership. Gross in 1973, \$150,000. Desire sabbatical for 2 years. Write or call J. V. G. Angel, M.D., 1705 McPherson, Council Bluffs, Iowa 51501. Call 712/328-2231, office or 712/323-1443, residence.

BUSY THREE-MAN FAMILY PRACTICE PARTNERSHIP in Marshalltown, Iowa (pop. 30,000) ueeds replacement for one partner leaving for a residency. Salary first year and then full partnership. Hospital facilities across the street, 200-bed well equipped hospital. Contact E. L. Jacobs, M.D., Marshalltown, Iowa 50158 for further details. Phone 515/752-3449.

GENERAL SURGEON (M.D.), Asst. Chief, Surgery, Bd. cert., exp. thoracic-vascular surg., salary accord. quals, modern 362 bed univ. affil. hosp., own residency, modern animal res. lab., fringe benefits, non-discrimination in employment, L. T. Palumbo, M.D., VA Hosp., Des Moines, Iowa 50310.

OTOLARYNGOLOGIST (M.D.), Sec. Chief, Bd. cert., full-time, modern 362-bed univ. affil. hosp, app. residencies gen, surg. & urology, modern animal res. lab, many fringes, nondiscrimination in employment, L. T. Palumbo, M.D., VA Hosp., Des Moines, Iowa 50310

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UROLOGIST (M.D.), Sec. Chief, Bd. cert., full-time; air-cond, 362 bed univ, affil, hosp. w/approved residency, excellent oppt. for urological research in lg. well-equipped animal lab., salary accord, quals, nondiscrimination in employment, L. T. Palumbo, M.D., VA Hosp., Des Moines, Iowa 50310.

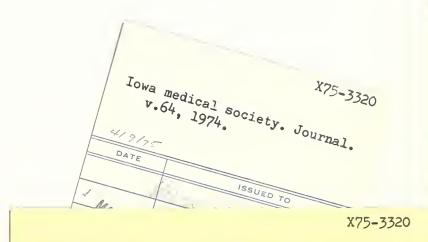
ORTHOPEDIC SURG. (M.D.) Sec. Chief, Bd. cert., full-time; 362 bed univ. affil. hosp., own residencies gen. surg. & urol., full fringes, salary accord. quals, nondiscrimination in employment, L. T. Palumbo, M.D., VA Hosp., Des Moines, Iowa 50310.

NAVY CAREERS NOW MORE ATTRACTIVE—Many physicians in military service may qualify for special pay of up to \$13,500 per year due to a new variable incentive pay bill. Eligibility is dependent on review of particular circumstances. Increments plus base pay and fringe benefits can bring annual income into line with civilian doctors. Today there's more reason than ever to look into the challenge of a Navy Medical Corps career. For complete information, please call toll free—515/284-4183, or contact Medical Programs, Navy Recruiting District, Room 693, Federal Building, Des Moines, Iowa 50309.









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